Arizona Medical Board

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FINAL MINUTES FOR REGULAR SESSION MEETING
Held at 9:30 a.m. on February 11, 2004, 8:00 a.m. on February 12, 2004, and 8:00 a.m. on February 13, 2004
9535 E. Doubletree Ranch Road · Scottsdale, Arizona

Board Members

Edward J. Schwager, M.D., Chairman
Sharon B. Megdal, Ph.D., Vice Chair
Robert P. Goldfarb, M.D., Secretary
Patrick N. Connell, M.D.
Ronnie R. Cox, Ph.D.
Ingrid E. Haas, M.D.
Tim B. Hunter, M.D.
Becky Jordan
Ram R. Krishna, M.D.
Douglas D. Lee, M.D.
William R. Martin III, M.D.
Dona Pardo, Ph.D., R.N.

Board Counsel

Christine Cassetta, Assistant Attorney General

Staff

Barry A. Cassidy, Ph.D., P.A.-C, Executive Director
Amanda J. Diehl, M.P.A., CPM, Assistant Director / Licensing & Operations
Barbara Kane, Assistant Director / Investigations & Quality Assurance
Beatriz Garcia Stamps, M.D., M.B.A., Board Medical Director
Gary Oglesby, Chief Information Officer
Tina Speight, Public Affairs Coordinator
Lisa McGrane, Legal and Communications Coordinator

WEDNESDAY, FEBRUARY 11, 2004

CALL TO ORDER

Edward J. Schwager, M.D., Chair, called the meeting to order at 8:02 a.m.

ROLL CALL

The following Board members were present: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N. and Edward J. Schwager, M.D. The following Board member arrived late to the meeting: Ingrid E. Haas, M.D. The following Board member was absent from the meeting: Ronnie R. Cox, Ph.D.

CALL TO THE PUBLIC

Statements issued during the call to the public appear beneath the case referenced.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
1.	MD-03-0170A	AMB	ASHRAF A. S. GERGES, M.D.	25594	Refer to Formal Hearing.

FORMAL INTERVIEWS (Continued) - ASHRAF A. S. GERGES, M.D.

Ashraf A.S. Gerges, M.D., appeared before the Board with his attorney Paul J. Giancola. Ingrid E. Haas, M.D., was not present for this matter. A.M. made a statement to the Board at the call to the public. A.M. informed the Board that Ashraf A.S. Gerges, M.D. was terminated from the practice for altering patient records and stated that Dr. Gerges has a responsibility to his patients to do everything that he can for them.

Rudolf Kirschner, M.D., Board Medical Consultant reviewed this case with the Board. The allegations in this case are that Dr. Gerges failed to adequately document the vascular status of a patient's lower extremities and then, when the patient developed complications, ordered that the patient's original medical records to be destroyed after he re-dictated an altered record, with the intention of replacing the original record of his treatment of this patient. Additionally, after termination from the practice, Dr. Gerges unethically attempted to solicit the patient away from the practice by claiming that he had opened a satellite office of that practice.

Dr. Gerges made a statement to the Board and stated that there is no truth to the allegations. Dr. Gerges stated that the Arizona Medical Board never obtained statements from his medical assistant or himself regarding the allegations brought against him. Dr. Gerges also stated that the first time he saw this patient was for pain around patient's right knee and leg, and the patient's calf was two and a half times the normal size and tender to the touch. Dr. Gerges stated that due to the patient's past medical history and the urgency of the situation, he diligently urged the patient to go to the emergency room and follow up with the his orthopedic physician, but the patient refused after three visits. Dr. Gerges informed the Board he could not have altered the records because he has a certain style in his notes, along with the handwriting of his medical assistant that is consistent with every office visit of the patient.

Patrick N. Connell, M.D., presenting Board member, began the questioning of Dr. Gerges. Dr. Gerges informed the Board that he had never heard of "Med Trans" the transcription company that transcribed Dr. Gerges' dictations from the two patient records in question. Dr. Gerges stated that his medical assistant always transcribed his dictations and he suggested that this complaint was created as a conspiracy against him. Dr. Gerges also stated that he normally writes his progress notes after a patient visit in a timely manner, but the progress notes for this patient were completed immediately after the patient's visit. Dr. Gerges informed the Board that the medical assistant typically took the dictation tapes home and transcribed them there. Dr. Gerges made changes later to ensure accuracy and quality. Dr. Gerges stated that Dr. Maurice was not being truthful when he informed the Board that Dr. Gerges altered patient records. Dr. Gerges stated that he had minimal contact with Dr. Maurice.

The Board members questioned Dr. Gerges and asked if he had been fired from the practice. Dr. Gerges stated that he wanted to learn more about the financial side of the practice and saw a consultant to get assistance in doing so. Dr. Gerges also stated that when he did so the practice recommended he either leave or move on. Dr. Gerges informed the Board that he questioned the financial books and therefore, someone was trying to make him look bad. The Board members pointed out to Dr. Gerges that the record to which he kept referring did not have the corrections on it that he described earlier. Dr. Gerges stated that the document was created for the purposes of this meeting to prove the handwriting and style are the same throughout his documents. Dr. Gerges stated that he never saw the transcript from Med Trans until his attorney brought it to his attention. Dr. Gerges stated that does not know why Carolyn Russell, the practice manager, would make these kinds of accusations against him and that she is lying.

Dr. Gerges made a statement to the Board and stated that he has given his sworn testimony and provided all the documentation related to the patient records in question.

Mr. Giancola made a statement to the Board. Mr. Giancola stated that Ms. Casillas, the medical assistant, has never been contacted or questioned by the Board regarding this matter. Mr. Giancola also stated that he provided an affidavit from Ms. Casillas stating that she never made the allegations stated in Ms. Russell's complaint to the Board. Mr. Giancola informed the Board that there are no tapes from Med Trans to identify the voice on the dictation tapes.

Patrick N. Connell, M.D., stated that one option is to refer this case to a formal hearing. Dr. Connell also stated that based on what was heard today, he found it incredible that someone would have created a second medical record and put it next to the patient's original record in order to have someone fired. Dr. Connell recommended that this physician has committed unprofessional conduct in violation of A.R.S. § 32-1401(26) - "Unprofessional conduct" includes the following, whether occurring in this state or elsewhere: (q) Any conduct or practice that is or might be harmful or dangerous to the health of the patient or public, (e) Failing or refusing to maintain adequate records on a patient, and (t) Knowingly making a false or fraudulent statement, written or oral, in connection with the practice of medicine or if applying for privileges or renewing an application for privileges at a health care institution. Dr. Connell stated that A.R.S. § 32-1401(26)(q) is justified because altering medical records is potentially harmful and dangerous to the public as a physician must be honest and not self-serving. Specifically, a physician should not create alternate records after a bad outcome. Dr. Connell stated that the standard is to produce contemporaneous medical records and document any alterations or changes with the date and time of the amendment.

FORMAL INTERVIEWS (Continued) - ASHRAF A. S. GERGES, M.D.

MOTION: Patrick N. Connell, M.D., moved for a finding of unprofessional conduct in violation of A.R.S. § 32-1401(26) - "Unprofessional conduct" includes the following, whether occurring in this state or elsewhere: (q) Any conduct or practice that is or might be harmful or dangerous to the health of the patient or public; (e) Failing or refusing to maintain adequate records on a patient; and (t) Knowingly making a false or fraudulent statement, written or oral, in connection with the practice of medicine or if applying for privileges or renewing an application for privileges at a health care institution.

Ram R. Krishna, M.D., stated that this case should be dismissed because Dr. Gerges has shown today by his testimony that he has not altered the patient's records. Dr. Krishna also stated that there is no record of the voice dictation that Med Trans used to transcribe the record.

MOTION: Ram R. Krishna, M.D., moved to dismiss this case.
SECONDED: Robert P. Goldfarb, M.D.

Dr. Goldfarb stated that he did not hear convincing information that Dr. Gerges altered the records of this patient and would suggest that this investigation continue. Dr. Krishna agreed. Sharon B. Megdal, Ph.D., stated that she would support a referral to formal hearing. Edward J. Schwager, M.D., stated that an evidentiary hearing might be of value in order to interview the witnesses for testimony. Douglas D. Lee, M.D., stated that he would not support the dismissal of this case, but would support a referral to formal hearing to determine if the records were falsified. Tim B. Hunter, M.D., stated that he agreed with Dr. Lee and would support a formal hearing in order subpoena all parties involved for testimony. Dr. Connell stated that he would support a referral to formal hearing also.

Ram R. Krishna, M.D., withdrew his motion to dismiss this case.

MOTION: Ram R. Krishna, M.D., moved to refer this case to formal hearing.
SECONDED: William R. Martin III, M.D.
VOTE: 9-yay, 1-nay, 0-abstain/recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
2.	MD-02-0740A	S.S.	MILUSE VITKOVA, M.D.	20176	Advisory Letter for making an amendment to an autopsy report without indicating that it was an amendment to the autopsy report. The violation is a minor technical violation that is not of sufficient merit to warrant disciplinary action.

Miluse Vitkova, M.D., appeared before the Board with her attorney Kraig J. Marton. S.S. made a statement to the Board at the call to the public. S.S. stated that this case involves the autopsy of her mother. The events from this case involving the autopsy of her mother will haunt her and her family for the rest of their lives.

Barbara Kane, Assistant Director of Investigations & Quality Assurance reviewed this case with the Board. The allegations in this case are that Dr. Vitkova negligently performed an unauthorized autopsy; failed to provide the patient's family with the complete body, since body parts and tissues were sold without permission; provided false and incorrect information in the autopsy report resulting in uncertainty regarding the identity of the person autopsied; and failure to properly supervise the actions of her assistant, both during and after the autopsy procedure. Dr. Vitkova was noticed on eight separate statutory violations.

Dr. Vitkova made a statement before the Board and stated that she performed the autopsy as she would normally perform any autopsy. Dr. Vitkova stated that she spoke with S.S., the complainant, before and after the autopsy regarding the findings and informed her that it would take some time to prepare the report. Dr. Vitkova also stated that she advised S.S. that the preliminary findings were not final. Dr. Vitkova stated she had resigned because of the harassment from S.S. along with the investigations and an audit that took place because of S.S.'s complaint to the hospital. Dr Vitkova stated that she is no longer doing independent autopsies. S.S. approached the Department of Health Services and three major newspapers informing them that Dr. Vitkova was selling tissues and organ parts illegally. Kraig J. Marton commented that S.S. made a campaign against Dr. Vitkova to ruin her career.

Dona Pardo, Ph.D., R.N., presenting Board member, began the questioning of Dr. Vitkova. Dr. Vitkova informed the Board thatsince she resigned, she has found work doing locum tenens in California as a pathologist, however, because of the Board's investigation she was denied malpractice insurance. Dr. Pardo stated that there are two autopsy reports that are different; the original autopsy report that was dated and the second autopsy report that was not dated.

FORMAL INTERVIEWS (Continued) - MILUSE VITKOVA, M.D.
Dr. Vitkova stated that she changed the kidney and body weight and wrote a second autopsy report with those changes because she was distressed about S.S.'s persistent phone calls for over one and a half years and felt pressure from S.S. to make those changes in order to appease S.S. Dr. Vitkova stated that she may not have noticed the scarring on the deceased because the breast surgery took place twenty years prior to death and scars tend to change after death as the scar becomes more pale. Dr. Vitkova stated that in her current practice, if the family of the deceased does not agree with her findings, she would not make changes to an autopsy report, but send it for a second opinion and would not continue discussions with the family.

The Board members questioned Dr. Vitkova. Dr. Vitkova stated that the weight of a body is estimated and a body is not actually weighed. The Board inquired as to why S.S. wanted the autopsy report changed to indicate toxemia. Dr. Vitkova responded by stating that S.S. was convinced that the physician treating her mother prior to her death was treating her wrong. Dr. Vitkova informed the Board that it is routine to identify a body first and also stated that the body parts, organs, or tissues of the deceased were not sold. Dr. Vitkova stated that it did not occur to her to do an addendum to the autopsy report as opposed to creating a new autopsy report.

Mr. Marton made a statement to the Board on behalf of Dr. Vitkova. Mr. Marton stated that an autopsy report is not a medical report that is used for the care and treatment of a patient, but a report to the family as to why a patient died. Mr. Marton also stated that the final diagnosis did not change the malpractice case. Mr. Marton referred the Board to Dr. Keen's report noting that Dr. Keen found that the changes made by Dr. Vitkova were insignificant except for the change of the kidney weight. Mr. Marton recommended issuing an advisory letter to Dr. Vitkova for that change. Mr. Marton urged the Board to dismiss this case or issue Dr. Vitkova a non-disciplinary advisory letter for changing the kidney weight. Mr. Marton also stated that Dr. Vitkova did not attempt to deceive anyone, as her final diagnosis did not change.

Ms. Kane clarified with the Board that Dr. Keen stated in his report that he found it inappropriate to change objective findings in any autopsy, such as kidney weight.

Dona Pardo, Ph.D., R.N., stated that an autopsy report is a medical record that Dr. Vitkova did change and recommended that the physician did commit unprofessional conduct in violation of A.R.S. § 32-1401(26) - "Unprofessional conduct" includes the following, whether occurring in this state or elsewhere: (t) Knowingly making a false or fraudulent statement, written or oral, in connection with the practice of medicine or if applying for privileges or renewing an application for privileges at a health care institution. Tim B. Hunter, M.D., stated that he agreed that an autopsy report is a medical record and is a very important record, but this does not rise to the level of discipline. William R. Martin III, M.D., and Ram R. Krishna, M.D., concurred with Dr. Hunter. Sharon B. Megdal, Ph.D., commented that changing a report is a very serious matter and clarified with Christine Cassetta, Board Counsel, that a separate finding of unprofessional conduct is not necessary in order to issue Dr. Vitkova an advisory letter unless the Board would like that finding documented in the meeting minutes. Dr. Megdal stated that she would support an advisory letter.

MOTION: Tim B. Hunter, M.D., moved to issue Dr. Vitkova an advisory letter for making an amendment to an autopsy report without indicating that it was an amendment to the original autopsy report. A.R.S. § 32-1401(3) - "Advisory Letter" means a non-disciplinary letter to notify a licensee that: (b) The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE was taken and the following members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N., and Edward J. Schwager, M.D. The following Board member was absent from the meeting: Ronnie R. Cox, Ph.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
3.	MD-02-0676A	AMB	DWIGHT C. LUNDELL, M.D.	6960	Refer to Formal Hearing.

Heather Hendrix appeared before the Board on behalf of Dwight C. Lundell, M.D. Ms. Hendrix informed the Board that Dr. Lundell was not available to appear before the Board because of being unexpectedly and unavoidably detained, but that she did have a statement from Dr. Lundell and would be happy to answer any questions on his behalf.

Edward J. Schwager, M.D., clarified with Christine Cassetta, Board Counsel, that the Board would not be able to proceed with the formal interview without Dr. Lundell. Ms. Cassetta informed the Board that their options would be to take Dr. Lundell's failure to appear as a refusal to appear and refer the matter to a formal hearing or grant a continuance, however a continuance is not normally granted at this point, absent exigent circumstances. The Board members confirmed with Ms. Hendrix that Dr. Lundell would not be able to appear before the Board for the duration of the week. Sharon B. Megdal, Ph.D., inquired of Ms. Hendrix as

to why Dr. Lundell was unable to appear. Ms. Hendrix reiterated that Dr. Lundell was unexpectedly and unavoidably detained, but if he could have appeared, he would have. Robert P. Goldfarb, M.D., inquired as to when Dr. Lundell and Ms. Hendrix learned that he would not be able to appear. Ms. Hendrix stated that Dr. Lundell informed her yesterday after hours and she did not attempt to notify the Board due to that fact. Dr. Goldfarb noted that the Board's offices opened at 8:00 a.m., yet neither Ms. Hendrix nor Dr. Lundell attempted to notify the Board until after 2:00 pm when the Board called the case.

MOTION: Patrick N. Connell, M.D., moved to refer this matter to formal hearing.
SECONDED: Ram R. Krishna, M.D.
VOTE: 11yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
4.	MD-03-0101A	AMB	STEVEN COHEN, M.D.	28261	Advisory Letter for performing a Lasik procedure on a patient with a severe astigmatism. The violation is a technical violation that is not of sufficient merit to warrant disciplinary action.

Steven Cohen, M.D., appeared before the Board with his attorney Peter Akmajian. Edward J. Schwager, M.D., stated that he has treated some of Dr. Cohen's patient's but has never met him and his ability to adjudicate this case will not be impacted.

Roderic Huber, M.D., Board Medical Consultant reviewed this case with the Board. The allegation in this case is that Dr. Cohen inappropriately attempted to perform Lasik surgery on a patient who was not a candidate for the procedure, based upon pre-existing corneal abnormalities.

Edward J. Schwager, M.D., presenting Board member, began the questioning of Dr. Cohen. Dr. Cohen described to the Board the difference between high astigmatism and corneal abnormalities. Dr. Schwager stated that Dr. Cohen provided many materials to support his decision, but the Board's Outside Medical Consultant did not agree with these materials. Dr. Cohen responded by stating it was not clear that the patient had keratoconus and that the materials he provided were from his educational training. Dr. Schwager stated that the patient records do not show the degree of conversation Dr. Cohen had with the patient. Dr. Cohen informed the Board that because the patient was an acquaintance of his, he did not write everything down in the patient's chart and because of this, he did not reflect that the patient desired good comfortable lenses due to the amount of reading the patient does. Dr. Cohen stated that he did review this case, specifically the topography, with a colleague who agreed there was a high amount of astigmatism, but did not find that this patient had keratoconus. Dr. Cohen explained the reasons why a buttonhole might occur, but in this patient, he believes it might have occurred because of the patient's steep cornea. Dr. Cohen stated that he reviewed these risks in length with the patient prior to surgery. Dr. Cohen expressed to the Board his desire to help an individual that he knew personally. To avoid a more serious operation such as a corneal transplant and based on the examination of the patient at that time, he felt that Lasik surgery would be the best option as a corneal transplant would still be an option if the Lasik surgery did not work.

The Board members questioned Dr. Cohen. Dr. Cohen stated that the patient does not have classic keratoconus but an unusual variance of it and did not have any of the presenting signs accompanied by it. Dr. Cohen stated he would not have performed the Lasik surgery if he had known that the patient had keratoconus. Dr. Cohen stated that the topography had two wings or bow tie appearance, a characteristic of astigmatism, and that is part of what led him to think this patient did not have keratoconus.

Dr. Cohen told the Board that there have been lessons learned from this experience and stated that he let a personal relationship affect his decision making, but if he had known the patient had keratoconus, he would not have performed the Lasik surgery. Dr. Cohen felt that a cornea transplant could have been avoided if the Lasik surgery was successful and his intentions to the patient were only to help him. Dr. Cohen also stated that he would stay within the FDA guidelines to perform surgeries. Dr. Cohen stated that he did not believe there was any kind of instability in the patient's cornea.

Mr. Akmajian made a statement to the Board on behalf of Dr. Cohen. Mr. Akmajian stated that the patient was heading towards a corneal transplant and Dr. Cohen was attempting to avoid it by performing the Lasik surgery and the question is if this patient would have needed a corneal transplant regardless. Mr. Akmajian also stated that Dr. Cohen has changed his practice and understands the merit of taking a conservative approach. Mr. Akmajian urged the Board that an advisory letter would be appropriate.

Roderic Huber, M.D., Board Medical Consultant reiterated to the Board that, whatever the condition of the cornea, the measurements were beyond the recommended guidelines for refractive surgery and secondly, trying this type of surgery was not just a bad idea, but contraindicated.

Edward J. Schwager, M.D., recommended issuing Dr. Cohen an advisory letter for an attempted performance of Lasik procedure on a patient whose eyes made him an extremely poor candidate. He stated there was a complication that Dr. Cohen

recognized immediately and then addressed. Dr. Schwager stated that the physician was not noticed on the lack of documentation relative to the informed consent, as there were a number of visits to discuss the procedure. This does not rise to the level of discipline and is a technical error. There has been education on the basis of this complaint, a mitigating factor. Patrick N. Connell, M.D., stated that from what he has learned from this case, he would support the motion. Sharon B. Megdal, Ph.D., referred to the Staff Investigational Review Committee report that noted the patient needed a corneal transplant and there has been testimony that this would have been necessary anyway. Tim B. Hunter, M.D., stated that he would support dismissal, as there were several notations that the patient had been informed of the risks of Lasik surgery, also the complication was promptly recognized.

MOTION: Edward J. Schwager, M.D., moved to issue an advisory letter for performing a Lasik procedure on a patient with a severe astigmatism. A.R.S. § 32-1401(3) - "Advisory Letter" means a non-disciplinary letter to notify a licensee that: (b) The violation is a technical violation that is not of sufficient merit to warrant disciplinary action.
SECONDED: Douglas D. Lee, M.D.
ROLL CALL VOTE was taken and the following members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N., and Edward J. Schwager, M.D. The following Board member voted against the motion: Tim B. Hunter, M.D. The following Board member was absent from the meeting: Ronnie R. Cox, Ph.D.
VOTE: 10-yay, 1-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
5.	MD-03-0378A	AMB	JOHN S. TRUITT, M.D.	21749	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for inappropriately treating a patient with radiation therapy to the brain without any evidence of brain metastasis on a magnetic resonance imaging (MRI) study.

John S. Truitt, M.D., appeared before the Board with his attorney Skip Donau. Robert P. Goldfarb, M.D., stated that he has spoken with Mr. Donau previously by phone to review a case, but this will not affect his ability to adjudicate this case.

Philip Scheerer, M.D., Board Medical Consultant reviewed this case with the Board. The allegation in this case is that Dr. Truitt inappropriately treated a patient who was suffering from ovarian cancer complicated by a thromboembolic stroke with radiation therapy to the brain without any evidence of brain metastasis on a magnetic resonance imaging (MRI) study.

John S. Truitt, M.D., made a statement to the Board. Dr. Truitt stated that the patient showed no signs of a stroke and had symptoms of nausea, vomiting, dizziness, and instability of gate approximately two to three weeks prior to her stroke. Dr. Truitt stated that the neurologist informed him that this could possibly be a stroke, but that metastatic disease could not be ruled out. Dr. Truitt also stated that he would not have been asked to see this patient unless there was a high index of suspicion that something was happening. Dr. Truitt stated that he reviewed the films and saw what he thought to be a lytic lesion and the magnetic resonance imaging (MRI) was suggestive of a separate focus within the internal capsule on the right side of the patient's brain. Dr. Truitt stated that he discussed this with the patient and with the referring physician and that if radiation therapy was to be administered, and indeed a metastatic focus caused a stroke in the first place, then this may have retarded or delayed further neurological compromise. Dr. Truitt stated that he discussed at length with the patient that they could delay and he offered a positron emission tomography (PET) scan. They were both in agreement that radiation therapy would be attempted.

Robert P. Goldfarb, M.D., presenting Board member, began the questioning of Dr. Truitt. Dr. Truitt stated that he treats approximately 1-2 patients per month with cancer of the brain and is not unusual to occur in a patient with ovarian cancer. Dr. Truitt stated the patient had something going on in her head for several weeks, culminating in a stroke and that the computed tomography (CT) scan was consistent with a stroke or edema, but had a suggestion of a mass. However, the results were not discussed with a radiologist. Dr. Truitt stated that the MRI was conclusive for a bleed, but there was a separate focus on the internal capsule on the right side. Dr. Goldfarb referred to the radiologist's report that stated that there were no findings to indicate skeletal metastatic disease. Dr. Truitt stated that he did suggest a PET scan, but one was not readily available in Casa Grande.

The Board members questioned Dr. Truitt. Dr. Truitt stated that his did not want to compromise the patient and tried to prevent devastating effects.

Mr. Donau made a statement before the Board on behalf of Dr. Truitt and stated that although it is rare that ovarian cancer can go to the brain, Dr. Truitt has experienced this type of disease. Mr. Donau stated that after the patient died, it was reported that

she had cancer of the nervous system. Mr. Donau stated that Dr. Truitt's conduct does not merit disciplinary action but dismissal or at the most an advisory letter.

The Board viewed the imaging scans. Tim B. Hunter, M.D., stated that he viewed the images and considered them normal without any sign of a lytic lesion, but agrees with the MRI of the brain.

Dr. Goldfarb stated the CT scan does not indicate a metastatic tumor as the radiologist concluded, but the MRI that clearly shows an infarction pattern. Dr. Goldfarb stated that the history, which was available from the patient's physicians, shows that this was a sudden onset and additional testing along with a second opinion should have been pursued. Dr. Goldfarb also stated that the decision to perform whole brain radiation, with the fact that there is less then two percent chance of ovarian cancer metastasizing to the brain, does not meet the standard of care in violation A.R.S. § 32-1401(26) - "Unprofessional conduct" includes the following, whether occurring in this state or elsewhere: (q) Any conduct or practice that is or might be harmful or dangerous to the health of the patient or public. The standard of care would have been not to perform whole brain radiation on a stroke patient without good evidence of a metastatic lesion.

Edward J. Schwager, M.D., stated that he would not support the recommendation for unprofessional conduct due to the issue of the physician's interpretations of the scan and if there was in fact metastatic disease of the brain the conduct was appropriate. Dr. Schwager also stated that the records the radiation oncologist reviewed with the patient's oncologist were contemplated with the hopes of a reasonable life before the cancer that would ultimately take her life regardless. Dr. Schwager stated that it would have been better to get additional testing or a second opinion, but this was clearly at a point where days made a difference for the outcome. Dr. Schwager commented that there was a lot of gray area with this case. Dr. Goldfarb stated that he disagreed with Dr. Schwager because the infarction is quite large and to perform whole brain radiation with edema does not improve the brain situation if there was concern for intercranial pressure. Dr. Goldfarb noted that he did not see from the records that the medical oncologist recommended radiation therapy.

MOTION: Robert P. Goldfarb, M.D., moved for a finding of unprofessional conduct in violation of A.R.S. § 32-1401(26) - "Unprofessional conduct" includes the following, whether occurring in this state or elsewhere: (q) Any conduct or practice that is or might be harmful or dangerous to the health of the patient or public.
SECONDED: Ram R. Krishna, M.D.
VOTE: 10-yay, 1-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

Dr. Hunter reiterated that he disagreed with Dr. Truitt's interpretation of the CT scan and the diagnostic radiologist report that did go along with what Dr. Truitt, testified today. However, the circumstances were confused with this patient and the situation was not handled to the best. Dr. Hunter stated that this was a one-time occurrence and would support an advisory letter for a technical infraction, as this does not rise to the level of discipline. Dr. Krishna stated that he would support the motion as stated by Dr. Goldfarb, particularly after listening to the testimony today and commented that this was an acute incident and not a chronic situation, and since the diagnostic studies were not conclusive, Dr. Truitt should not have been so quick to have the patient go through radiation therapy. William R. Martin III, M.D., clarified with Dr. Goldfarb that radiation therapy would have exacerbated swelling of the brain, specifically in a patient with an infarct, as this would be a compromised brain. He also clarified that the recommendation for unprofessional conduct was a violation of A.R.S. § 32-1401(26)(q) because of potential harm done to the patient due to the limited amount of radiation versus A.R.S. § 32-1401(26)(ll) which would be actual harm done to the patient.

MOTION: Robert P. Goldfarb, M.D., moved for Board staff to draft findings of fact, conclusions of law and order for a letter of reprimand for inappropriately treating a patient with radiation therapy to the brain without any evidence of brain metastasis on a magnetic resonance imaging (MRI) study.
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE was taken and the following members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., and Sharon B. Megdal, Ph.D. The following Board member voted against the motion: Tim B. Hunter, M.D., William R. Martin III, M.D., Dona Pardo, Ph.D., R.N., and Edward J. Schwager, M.D. The following Board member was absent from the meeting: Ronnie R. Cox, Ph.D.
VOTE: 7-yay, 4-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
6.	MD-02-0583A	AMB	JEFFREY A. LEVISON, M.D.	20369	Advisory Letter for obtaining inadequate history of a patient in an urgent care setting. The violation is a technical violation that is not of sufficient merit to warrant disciplinary action.

FORMAL INTERVIEWS (Continued) - JEFFREY A. LEVISON, M.D.
Jeffrey A. Levison, M.D., appeared before the Board with his attorney Timothy Kasparek.

Philip Scheerer, M.D., Board Medical Consultant reviewed this case with the Board. The allegation in this case is that Dr. Levison failed to timely diagnose and treat pneumococcal pneumonia and sepsis in a 36-year-old asplenic patient resulting in death.

Dr. Levison made a statement to the Board and stated that the outcome of this case was very unfortunate. Dr. Levison stated that the patient was morbidly obese and this could account for some of his condition. Dr. Levison also stated that the patient presented with classic influenza symptoms that occurred suddenly during a flu outbreak and this is why Dr. Levison thought the patient had influenza. Dr. Levison stated that he did ask the patient if he had any past medical history that he would need to know about and the patient said no. Dr. Levison stated that the only abnormal vital was his heart rate at 118 and the influenza could account for this. Dr. Levison also stated that he did not fall below the standard of care in the treatment of this patient.

Patrick N. Connell, M.D., presenting Board member began the questioning of Dr. Levison. Dr. Connell commented that in the midst of an influenza epidemic, it seems that the patients have similar symptoms, but physicians are responsible for recognizing the difference. Dr. Connell discussed with Dr. Levison the medical records of the patient from Casa Blanca Medical Clinic and also discussed the importance of retrieving a medical history from the patient. Dr. Connell stated that this patient had a significant past medical history in that his spleen had been removed. Dr. Levison stated that he did ask the patient if he had any previous medical conditions that he needed to know about, although, he did not ask the patient specifically if he had ever had surgery, or if he was ever hospitalized.

The Board members questioned Dr. Levison. Ram R. Krishna, M.D., asked Dr. Levison to explain the heart rate of 118 yet otherwise normal vital signs. Dr. Levison responded by informing the Board that he felt the rate of 118 was due to the fact that the patient had just been walking and a second rate was taken and it was normal.

Mr. Kasparek made a statement to the Board on behalf of Dr. Levison. Mr. Kasparek stated that we would not have been here if the patient informed Dr. Levison that he did not have a spleen. Mr. Kasparek stated that he believes if this case had been tried, the jury would have attributed some of the responsibility for the outcome to the patient. Mr. Kasparek also stated that Dr. Friedman, who is one of Board's Outside Medical Consultants, finds it incredible that the patient did not know the facts of being asplenic. Mr. Kasparek urged the Board not to impose a disciplinary action and this case should receive an advisory letter if not be dismissed.

Dr. Scheerer commented that the patient did present with the symptoms of bacteremia and one could diagnose pneumococcal sepsis in a patient with a spleen. Dr. Scheerer also stated that it is possible that a patient may not know the significance of being asplenic.

Patrick N. Connell, M.D., stated that in an urgent care or emergency care setting it is the physician's responsibility to get the basic medical history of a walk in-patient because in that situation there is no history available. Dr. Connell stated that Dr. Levison fell below the standard of care.

MOTION: Patrick N. Connell, M.D., moved for a finding of unprofessional conduct for failing to obtain and document of past surgical history and failure to do an adequate physical examination including an abdominal examination in violation of A.R.S. § 32-1401(26) - "Unprofessional conduct" includes the following, whether occurring in this state or elsewhere: (q) Any conduct or practice that is or might be harmful or dangerous to the health of the patient or public and (ll) Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.
SECONDED: Ram R. Krishna, M.D.
VOTE: 5-yay, 5-nay, 1-abstain/recuse, 1-absent
MOTION FAILED.

Dr. Hunter stated that he would not support the motion for unprofessional conduct because in the middle of an influenza epidemic and a busy practice the physician did fine and the physician is not expected to perform an abdominal examination to look for surgery scars. Dr. Hunter stated that he would support dismissal. Edward J. Schwager, M.D., stated that he would not support dismissal or support the statutes cited for unprofessional conduct. Dr. Schwager stated that the physician asked the patient of his general past medical history, but the patient failed to inform Dr. Levison of this information.

MOTION: Tim B. Hunter, M.D., moved to dismiss this case.
Motion failed for lack of a second.

FORMAL INTERVIEWS (Continued) - JEFFREY A. LEVISON, M.D.
Dr. Goldfarb stated that an advisory letter would be appropriate in this case because in the urgent care center Dr. Levison performed his duties in a standard way. However, he was not as thorough as he should have been.

MOTION: Robert P. Goldfarb, M.D., moved to issue an advisory letter for obtaining inadequate history of a patient in an urgent care setting. A.R.S. § 32-1401(3) - "Advisory Letter" means a non-disciplinary letter to notify a licensee that: (b) The violation is a technical violation that is not of sufficient merit to warrant disciplinary action.
SECONDED: Ingrid E. Haas, M.D.
ROLL CALL VOTE was taken and the following members voted in favor of the motion: Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Tim B. Hunter, M.D., Becky Jordan, Douglas D. Lee, M.D., William R. Martin III, M.D., Dona Pardo, Ph.D., R.N., and Edward J. Schwager, M.D. The following Board members voted against the motion: Patrick N. Connell, M.D. and Ram R. Krishna, M.D. The following Board member abstained from the motion: Sharon B. Megdal, Ph.D. The following Board member was absent from the meeting: Ronnie R. Cox, Ph.D.
VOTE: 8-yay, 2-nay, 1-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
7.	MD-03-0562A	AMB	SCOTT H. YALE, M.D.	24180	Advisory Letter for prescribing controlled substances to members of the physician's immediate family. This is a technical violation that is not of sufficient merit to warrant disciplinary action, the violation was limited in scope and the physician has changed his practice.

Scott H. Yale, M.D., appeared before the Board without legal representation.

Robert Barricks, M.D., Board Medical Consultant reviewed this case with the Board. The allegation in this case is that Dr. Yale was unprofessional on May 29, 2003 when he wrote a prescription for Percocet for an immediate family member.

Dr. Yale made a statement before the Board and asked them to reconsider the action pending against him. Dr. Yale stated that he wrote the prescription for his wife and explained that the prescription was written so that he and his wife would have the proper medications while hiking/mountain climbing in remote areas. Dr. Yale did not try to obtain narcotics and realizes he was wrong in writing the prescription.

Sharon B. Megdal, Ph.D., presenting Board member, began the questioning of Dr. Yale. Dr. Yale stated that he was not familiar with the Medical Practice Act regarding writing prescriptions for controlled substances to family members, as he is an anesthesiologist. This prescription was written approximately one year ago and was written to replace an existing soon to be expired prescription.

The Board members began questioning Dr. Yale. Ram R. Krishna, M.D., verified with Dr. Yale that Dr. Yale also wrote the original prescription.

Dr. Megdal stated that Dr. Yale admittedly violated the Medical Practice Act. Dr. Megdal stated that the prescription was never filled and recommended issuing Dr. Yale an advisory letter.

MOTION: Sharon B. Megdal, Ph.D., moved to issue an advisory letter for prescribing controlled substances to a member of the physician's immediate family. This is a technical violation of limited scope and the physician has changed his practice. A.R.S. § 32-1401(3) - "Advisory Letter" means a non-disciplinary letter to notify a licensee that: (b) The violation is a technical violation that is not of sufficient merit to warrant disciplinary action.
SECONDED: Patrick N. Connell, M.D.
ROLL CALL VOTE was taken and the following members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N., and Edward J. Schwager, M.D. The following Board member was absent from the meeting: Ronnie R. Cox, Ph.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NON-TIME SPECIFIC ITEMS

CHAIR'S REPORT

Auditor General's Confidential Preliminary Audit Review

The Board, upon a majority vote of a quorum of the members, may hold an *Executive Session* vote to discuss this confidential document in Executive Session pursuant to A.R.S. § 38-431.03 (A)(2)

MOTION: Edward J. Schwager, M.D., moved to go into executive session at 5:13 p.m.
SECONDED: Dona Pardo, Ph.D., R.N.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

The Board returned to open session at 7:02 p.m.

Federation of State Medical Boards Conference

Edward J. Schwager, M.D., confirmed by a show of hands which Board members were attending the Federation of State Medical Boards Conference.

Update on the Process for the Executive Director's Performance Evaluation

Edward J. Schwager, M.D., informed the Board that the subcommittee for the Executive Director's performance evaluation is near completion regarding the questionnaires to be used for the 360-degree evaluation. Dr. Schwager stated that the formal review is to be placed on the April 2004 Board meeting agenda. Dr. Schwager also informed the Board that the evaluation form is completely confidential.

Investigations/Quality Assurance – SIRC Presentation

Barbara Kane, Assistant Director of Investigations & Quality Assurance, presented the Staff Investigational Review Committee (SIRC) report to the Board. Ms. Kane reviewed the previous process of SIRC. Ms. Kane also reviewed the current process that includes the review of an average of six cases per week. Ms. Kane stated that SIRC has increased its voting members from three to five, which include the Medical Director, a Staff Medical Consultant on a rotating basis, the Assistant Director of Licensing and Operations, the Intake Officer, and the Assistant Director of Investigations and Quality Assurance. Ms. Kane stated that if legal advice is necessary, a teleconference call is made to the Assistant Attorney General. Due to the newly formed Quality Assurance division, cases are pre-screened and returned for further investigation or forwarded to SIRC.

The Board members suggested that the current physician assistant position for writing the allegations on quality of care cases be re-written to include a licensed medical professional rather than specifically a physician assistant. The Board members voiced concern that members of the public are indicating that they are only being contacted at the beginning of the case and then only hear from the Board when the case is dismissed. The Board members suggested implementing a process in order to keep a complainant informed of the status of the case. Barry A. Cassidy, Ph.D., P.A.-C, Executive Director, informed the Board members that the Board is heading in that direction with the on-line complaint filing and tracking system recently put in place.

MOTION: Tim B. Hunter, M.D., moved to accept the process as presented.
SECONDED: Ram R. Krishna, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

The meeting adjourned at 7:30 p.m.

THURSDAY, FEBRUARY 12, 2004

CALL TO ORDER

Edward J. Schwager, M.D., Chair, called the meeting to order at 8:01 a.m.

ROLL CALL

The following Board members were present: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N., and Edward J. Schwager, M.D. The following Board member was absent from the meeting: Ronnie R. Cox, Ph.D.

CALL TO THE PUBLIC

Statements issued during the call to the public appear beneath the case referenced.

RECOMMENDATION FOR NON-DISCIPLINARY ACTION

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
1.	MD-03-0102A	AMB	WENDY WOOTTON, M.D.	17689	Advisory Letter for failure to examine the patient pre-operatively and for changing the operative plan without documentation of informed consent from the patient.
2.	MD-03-0026A	AMB	E. CHARLES BLANCK, M.D.	11485	Advisory Letter for over prescribing Percocet resulting in patient addiction and hospitalization for detoxification.

Tim B. Hunter, M.D., recused himself from this matter.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
3.	MD-03-0274A	AMB	STEPHANIE A. SEDIVY, M.D.	24601	Advisory Letter for misdiagnosing a malignant melanoma as a benign compound nevus.
4.	MD-03-0457A	D.L.	DAVID M. LYMAN, M.D.	29294	Advisory Letter for failure to advise the patient of an abnormal test result.
5.	MD-94-0600	J.K.	DALE F. WEBB, M.D.	3492	Dismissed.

Case number 5 was pulled from the block vote for individual consideration. Ram R. Krishna, M.D., recused himself from this matter.

Attorney Michael Bradford made a statement to the Board at the call to the public with and on behalf of Dale F. Webb, MD. Mr. Bradford stated that this case occurred in 1994. Mr. Bradford urged the Board that an advisory letter is not justified and the Board should carefully consider dismissing the case.

Edward J. Schwager, M.D., stated that it is clear that dismissal would appropriate. Robert P. Goldfarb, M.D. requested that William Kennell, M.D., Board Medical Consultant bring the Board up to date on this case. Dr. Kennell stated that Dr. Webb was practicing in a setting where he saw many patients in a day. Considering that setting, Dr. Webb's conduct was within the standard of care. The patient also bore the responsibility to return for continued care. Sharon B. Megdal, Ph.D., commented the Board's process has changed due to the litigation in this case.

MOTION: Sharon B. Megdal, Ph.D., moved to dismiss this case.
SECONDED: Becky Jordan
VOTE: 10-yay, 0-nay, 1-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
6.	MD-03-0132A	AMB	WARREN ZEITLIN, M.D.	20208	Advisory Letter for failure to recognize the severity of the patient's problem and treat the patient aggressively.

MOTION: Ram R. Krishna, M.D., approve the advisory letters in case number 1, 2, 3, 4, and 6 except for case number 5, which was discussed individually.
SECONDED: Douglas D. Lee, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

APPEAL OF ED ACTION TIME SPECIFIC MATTERS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
1.	MD-02-0770A	AMB	GARY L. LOWERY, M.D.	24907	Appeal Withdrawn.

Steve Wolf, Assistant Attorney General, requested that the Board table this matter until tomorrow afternoon.

MOTION: Patrick N. Connell, M.D., moved to table this matter until tomorrow.
SECONDED: Ram R. Krishna, M.D.
VOTE: 11-yay, 0-yay, 0-abstain/recuse, 1-abstain
MOTION PASSED.

On February 13, 2004, Ms. Cassetta informed the Board on behalf of Mr. Wolf that counsel for Dr. Lowery had withdrawn his appeal as the parties were close to executing a Consent Agreement.

FORMAL HEARING MATTERS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
1.	MD-01-0150	W.L.	WILLIAM E. MORA, M.D.	13088	Rescind Referral to Formal Hearing and issue an Advisory Letter for poor documentation of the physical examination of the patient's hand. The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.

Susan Anderson, attorney for the State reviewed this case with the Board. Ms. Anderson stated that after review of the evidence she is recommending an advisory letter. Ms. Anderson also stated that the patient has since accepted the physician's apology and does not wish to proceed further against Dr. Mora. Ms. Anderson stated that documentation was of concern and recommended an advisory letter based on that.

Mr. Bradford made a statement to the Board at the call to the public.

MOTION: Ram R. Krishna, M.D., moved to rescind referral to formal hearing and issue an advisory letter for poor documentation of physical examination of patient. A.R.S. § 32-1401(3) - "Advisory Letter" means a non-disciplinary letter to notify a licensee that: (b) The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.
SECONDED: William R. Martin III, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
2.	MD-03-0859A	C.B.	JOHN M. RITLAND, M.D.	17268	Revocation, Stayed, with a ten year Probation, Dr. Ritland must have a female chaperone present if he treats female patients under the age of eighteen years. The female chaperone shall make a notation in the patient's chart indicating the chaperone's present during the encounter. As part of the Probation, he shall comply with Dr. Gray's recommendations except polygraph testing is not necessary. After successful completion of five years Probation, respondent may request modification of the Probation. Any violations of the terms of Probation shall result in Revocation. Dr. Ritland shall be assessed the costs of the hearing.

John M. Ritland M.D. appeared with counsel Robert Milligan. R.C. made a statement to the Board at the call to the public. R.C. spoke in support of Dr. Ritland. R.C. works with Dr. Ritland and has witnessed him in the examination room with patients. She has never seen examinations handled inappropriately nor heard one patient complain of Dr. Ritland's professionalism. R.C. stated that Dr. Ritland has a very loyal following and his patients have shown overwhelming support for him. R.C. cannot and will not believe that Dr. Ritland has ever molested anyone.

L.B. made a statement to the Board at the call to the public and stated that she has been a patient of Dr. Ritland since she was 18 years of age. Dr. Ritland treated her with the utmost respect as a patient and she had discussions with him as a patient regarding her sexual well-being. L.B. returned to Dr. Ritland to deliver her children and Dr. Ritland took the time to get to know her husband also. L.B. stated that Dr. Ritland is the only physician who has made her feel that she is his only patient.

K.R. made a statement to the Board at the call to the public on behalf of her father. K.R. stated that her best friend has accused her father. K.R. stated that her friends have lied about her dad. K.R. informed the Board that her friends also lied about the birth control pills prescribed to them.

Robert P. Goldfarb, M.D., informed the Board that he has had professional contact with Robert Milligan on behalf of his practice, but it will not affect his ability to adjudicate this case.

Dean Brekke, Assistant Attorney General, reviewed this case with the Board on behalf of the State. Mr. Brekke stated that what the Board was not able to see the demeanor of the witnesses and how this incident has affected them. Based on the findings by the Administrative Law Judge, one can see that the judge found the witnesses credible. Mr. Brekke stated that the facts in this case support a very serious consideration by this Board to decide if Dr. Ritland will practice in the State of Arizona. Dr. Brekke recommended revocation of Dr. Ritland's license.

FORMAL HEARING MATTERS (Continued) - JOHN M. RITLAND, M.D.

Dr. Ritland informed the Board that he never molested the complainants. Dr. Ritland stated that he loves his practice, as there is nothing better than delivering babies. Dr. Ritland stated that he has been available for his patients 24 hours a day 7 days a week for the past 19 years and that he has made sacrifices by missing family events, but his family has been supportive. Dr. Ritland stated that he has witnessed the effects of child abuse through his practice and knows how it affects the victims and would never do anything like he is being accused. Dr. Ritland asked that the Board members read the transcripts and stated that he is certain that the Board will know the truth that he did not molest these girls.

Robert Milligan made a statement to the Board on behalf of Dr. Ritland and stated that if Dr. Ritland had done the things he has been accused of he should be revoked and also asked the Board to look at the facts. Mr. Milligan stated that the judge's decision was a horrible mistake because he did not know whom to believe so he recommended restricting Dr. Ritland's practice. Mr. Milligan stated that this is not a case to be compromised. Mr. Milligan urged the Board to look at the facts because of the magnitude of what the Board has to decide and the Board's decision will affect Dr. Ritland and his family. Mr. Milligan also stated that after reading the testimony of Dr. Ritland's accusers, the Board would conclude that the witnesses are not telling the truth and their stories are full of inconsistencies. Mr. Milligan urged the Board to review the credibility of the witnesses. Mr. Milligan suggested to the Board that they do not take his word or the judge's, but look at the transcripts. Mr. Milligan also stated that in America there is a judicial system and in that system, jurors are not free from bias. Instead the system creates an environment where one grinds away to get at the truth. Mr. Milligan stated that if the Board does not evaluate the evidence, all fates rest on one person and no one person should have that much power. Mr. Milligan stated that the accusations themselves have ruined Dr. Ritland's practice.

Edward J. Schwager, M.D., noted that the Board should first focus on the findings of fact as a discussion prior to the conclusions of law.

MOTION: Sharon B. Megdal, Ph.D., moved to go into executive session at 8:48 a.m.
SECONDED: Robert P. Goldfarb, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

The Board returned to open session at 9:13 a.m.

Sharon B. Megdal, Ph.D., recommended that the Board adopt findings of fact numbers 1 through 15 as recommended by the Administrative Law Judge. Dr. Megdal recommended changing the wording in findings of fact number 16 from "events that occurred" to "following events that occurred." Edward J. Schwager, M.D., stated that the general issues in the findings of facts are the sexual allegations. Ram R. Krishna, M.D., stated that conclusions of law number 11 states different as far as the records are concerned. Dr. Schwager clarified that he was referring to findings of facts number 13 and conclusions of law number 12, which is where the physician and the judge are at odds. Dr. Krishna stated that the Administrative Law Judge developed findings of facts from the process of listening to the plaintiffs, defendants and witnesses and inquired as to why the Board would change anything on the findings of facts, except for the conclusions of law? Dr. Schwager stated that the question comes to the evidence, specifically with L.B. and determining the truth. Dr. Schwager stated that the question to discuss is the totality of the record and having read the transcripts, there are discrepancies on the part of L.B. and R.B. as to what occurred. Dr. Schwager also stated that there are issues regarding the overall credibility with the actions described, the relationships alleged and the ongoing visits with Dr. Ritland. There are some issues with the lack of attempting to find collaborating evidence and witnesses to support the allegations. Tim B. Hunter, M.D., stated that he agrees with Dr. Schwager and has specific concerns of the allegation of inappropriate touching and kissing and the allegation of poor record keeping. Dr. Megdal stated that the problem lies with the facts as proposed by the Administrative Law Judge and the Board should revoke Dr. Ritland's license, a serious matter. Dr. Megdal stated that with the transcripts reviewed, she is unsure of the result, as it is the Board's job to protect the public, but there is a physician's license on the line. Dr. Megdal stated that the physician seems to have some boundary issues. Dr. Hunter stated there are only about 6 findings of facts that seem to be troublesome and stated his concern if there were inappropriate touching and kissing. Dr. Krishna concurred with Dr. Hunter. Dr. Schwager stated that if conclusions of law number 5 were changed to findings of fact, it would help with the issues of what the findings of fact are. Dr. Schwager commented that based on his overall view of the investigative materials and transcripts that he does not believe R.B. and L.B. are credible. Dr. Krishna questioned how the Board could not see R.B. and L.B. as credible when the Administrative Law Judge determined that they were. Christine Cassetta, Board Counsel, stated that while the Board is free to make changes to the findings of fact, it must do so only after referencing evidence in the record to explain the change, however, the finding of credibility is not as easily changed. Dr. Schwager stated that there is an issue of credibility and what seems to be unreasonable.

MOTION: Sharon B. Megdal, Ph.D., moved to go into executive session at 9:46 a.m.
SECONDED: Robert P. Goldfarb, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

FORMAL HEARING MATTERS (Continued) - JOHN M. RITLAND, M.D.

The Board returned to open session at 10:24 a.m.

MOTION: Sharon B. Megdal, Ph.D., moved to continue this case until Friday 13, 2004 in the afternoon at 3 p.m.
SECONDED: Ram R. Krishna, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

The Board resumed consideration of this matter on February 13, 2004. C.B. made a statement to the Board at the call to the public on February 13, 2004. C.B. stated that her daughters are credible since the police believe them and the Administrative Law Judge believes them and found them to be credible. C.B. also stated that her daughter is now going through therapy. C.B. informed the Board that Dr. Ritland went behind her back and prescribed birth control and other prescriptions after she specifically directed him not to.

R.B. made a statement to the Board at the call to the public. R.B. stated that she has been destroyed emotionally and spiritually, and this has affected others around her. R.B. also stated that it has taken a lot to come forward and that she has nothing to gain from doing so.

L.B. made a statement to the Board at the call to the public and stated that she has no reason to lie and has nothing to gain by this. L.B. stated that K.R. saw Dr. Ritland touching L.B. and R.B. L.B. stated that the reason for the inconstancies is that they did not keep journals and they were younger at the time this happened. L.B. stated that Dr. Ritland did not have the authority to provide prescriptions to L.B. and R.B. and that Dr. Ritland would do anything to hide the fact of his molestation of them.

Dr. Schwager stated that in his statements yesterday he made reference to “the Board” having concerns rather than he himself having concerns and he wanted to clarify that the Board did not come to any consensus in Executive Session and he was speaking only on his own behalf. Dr. Connell stated that he recalled from yesterday that findings of facts numbers 1 through 15 were agreed on as acceptable. Dr. Connell stated that after hearing the arguments from counsel yesterday and after re-reading the testimony of the two principal complainants and the testimony of Dr. Ritland, that there were some significant boundary issues violated in Dr. Ritland’s household and that he has issues, nonetheless, the evidence read does not convince Dr. Connell that Dr. Ritland’s license should be revoked and he may prefer a Board Order similar to the Administrative Law Judge with some modifications. Dr. Krishna stated that he also re-reviewed and the findings of facts as recommended from the Administrative Law Judge and concluded that they should not be changed since the Administrative Law Judge heard both sides and saw the witnesses in person. Dr. Connell stated that if the phrasings in the findings of fact are left as is, it implies that the testimony of the people that testified is stated as fact, and therefore recommends that the wording be changed along with conclusion of law 5, which should really be a finding of fact. Ms. Cassetta advised that the Administrative Law Judge having put these findings as findings of fact indicates that he has decided that the testimony was truthful. Ms. Cassetta stated to the Board that she had recommended changes based on typographical errors in paragraph 36 beginning with line two, which should say “a patient doctor relationship” and in paragraph 40 the end of the first line, which should say “one or the others” and on page 7 findings of fact number 59 in the third line, which should say “one year”.

The Board discussed the Board Investigator’s testimony that there were inconsistencies between R.B.’s statement to the police and to the Board.

MOTION: Tim B. Hunter, M.D., moved to adopt the findings of facts as recommended by the Administrative Law Judge and change conclusions of law number 5 to a findings of facts with the changes as stated by Ms. Cassetta and add a finding regarding the Board Investigator testimony about the inconsistencies between R.B.’S statements the police and the Board.
SECONDED: Ram R. Krishna, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

MOTION: Sharon B. Megdal, Ph.D., moved to go into executive session at 3:32 p.m.
SECONDED: Robert P. Goldfarb, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

The Board returned to open session at 3:36 p.m.

FORMAL HEARING MATTERS (Continued) - JOHN M. RITLAND, M.D.

MOTION: Becky Jordan moved to add the following as conclusion of law number 5 "Because the hearing officer actually saw the witnesses and heard the evidence he is in the best position to determine the facts and may be the only appropriate person to make decisions on credibility of the witnesses. *In re Pima County Juvenile Action No. 63212-2,* 129 Ariz. 371, 374, 631 P.2d 526, 529 (1981)," to adopt conclusions of law numbers 6 and 7 as recommended by the Administrative Law Judge and edit conclusions of law number 8 to "The conduct and circumstances described in the above findings of fact does constitute unprofessional conduct by Respondent pursuant to A.R.S. § 32-1401(26)(d) committing a felony, whether or not involving moral turpitude, or a misdemeanor involving moral turpitude. In either case, conviction by any court of competent jurisdiction or a plea of no contest is conclusive evidence of the commission", delete conclusions of law number 9, 11 and 15, edit conclusions of law number 10 by removing the "not" from the phrase "does not constitute", adopt conclusions of law numbers 12, 13, 14, and 16 as recommended by the Administrative Law Judge, edit conclusion of law number 17 from "should" to "may" and re-number accordingly.
SECONDED: Ram R. Krishna, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

MOTION: Patrick N. Connell, M.D., moved that the respondent be issued a decree of censure and placed on probation for a period of five years and during the period of probation Dr. Ritland is to have a female chaperone present when treating patient's under the ages of 18.
SECONDED: Ram R. Krishna, M.D.

Dr. Connell withdrew his motion.

Dr. Hunter recommended a stayed revocation with probation for ten years and after successful completion of five years the respondent may apply to the Board for modification, but if a violation of the Order occurs this will immediately end in revocation. Dr. Megdal stated that she would support Dr. Hunter's recommendation. Dr. Schwager stated that he would not support a stayed revocation, as there were inconstancies pointed out by the Boards investigator and this Board must err on the side of protecting the public and having a female chaperone for patient's under the age of 18 is appropriate. Dr. Hunter stated that the Board has found that the evidence is credible and both attorneys have suggested that if the evidence were true then a stayed revocation is necessary and we have found by the findings of facts and conclusions of law that these are very serious charges. Dr. Hunter stated that Dr. Ritland's conduct was very serious and he needed to understand that he has gone to the precipice. Dr. Connell stated that he would support the Dr. Hunter's recommendation for the stayed revocation. Dr. Connell withdrew his motion to issue a decree of censure.

MOTION: Patrick N. Connell, M.D., moved for a Revocation, Stayed, with a ten year Probation, Dr. Ritland must have a female chaperone present if he treats female patients under the age of eighteen years. The female chaperone shall make a notation in the patient's chart indicating the chaperone's presence during the encounter. As part of the Probation, he shall comply with Dr. Gray's recommendations except polygraph testing is not necessary. After successful completion of five years Probation, respondent may request modification of the Probation. Any violations of the terms of Probation shall result in Revocation. Dr. Ritland shall be assessed the costs of the hearing.
SECONDED: William R. Martin III, M.D.
ROLL CALL VOTE was taken and the following members voted in favor of the motion: Patrick N. Connell, M.D., Ingrid E. Haas, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., William R. Martin III, M.D., Sharon B. Megdal, Ph.D., and Dona Pardo, Ph.D., R.N. The following Board member voted against the motion: Edward J. Schwager, M.D. The following Board member abstained from the motion: Robert P. Goldfarb, M.D., and Douglas D. Lee, M.D. The following Board member was absent from the meeting: Ronnie R. Cox, Ph.D.
VOTE: 8-yay, 1-nay, 2-abstain/recuse, 1-absent
MOTION PASSED.

FORMAL INTERVIEWS (Continued)

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
1.	MD-02-0616A	AMB	SYLVAIN SIDI, M.D.	8458	Dismissed.

Sylvain Sidi, M.D. appeared before the Board with his attorney Dan Jantsch. Edward J. Schwager, M.D., Robert P. Goldfarb, M.D., and Tim B. Hunter, M.D., recused themselves from this matter.

Philip Scheerer, M.D., Board Medical Consultant reviewed this case with the Board. The allegation in this case is that Dr. Sidi negligently performed an endoscopic cholangiopancreatography (ERCP) at Tucson Medical Center.

Douglas D. Lee, M.D., presenting Board member began the questioning of Dr. Sidi. Dr. Sidi stated his practice is office based with office and hospital consultations. Dr. Lee questioned Dr. Sidi's comment in the case materials that he passed the scope

FORMAL INTERVIEWS (Continued) - SYLVAIN SIDI, M.D.

blindly. Dr. Sidi stated that the scope is passed through the esophagus while viewing a monitor as the right hand advances with no need to manipulate the controls; the thumb of the left hand is what controls the endoscope. Dr. Sidi stated that on the pass of the third scope there was a possibility of any spasm or obstruction. Dr. Sidi stated that he felt resistance to push or pull the scope. Dr. Sidi stated that he has performed approximately 15,000 endoscopies in his career. Dr. Sidi stated that the patient came in to see him 10 days after the onset of abdominal pain. Dr. Lee inquired how the perforation occurred and Dr. Sidi stated that it was due to the three previous surgeries that modified the anatomy.

The Board members questioned Dr. Sidi. Dr. Sidi stated he has never had a perforation of the esophagus before.

William Kennell, M.D., Board Medical Consultant, commented that he is in complete agreement with Dr. Sidi as to the indications for the ERCP and to do less with a situation unknown could be very serious. Dr. Kennell stated that the diagnosis with the symptoms that occurred concurred with this patient.

Dr. Sidi made a statement to the Board and stated that the patient had the best care given to her. The outcome was good, but he was devastated at what happened.

Dr. Lee stated as to the first allegation there were indications that this allegation is unfounded and the testimony makes it very clear that the indications were there for the ERCP, also, in terms of the second allegation of the aggressive manipulation of the scope, from the testimony and evidence, is not substantiated. Dr. Lee stated that the only criticism is that a hand on the control feeling and turning might be helpful when passing the scope blindly, however, Dr. Sidi did not fall below the standard of care and this was a one time occurrence. Dr. Lee also stated that Dr. Sidi made no attempt to blame anyone or anything else for this but himself, which is commendable.

MOTION: Douglas D. Lee, M.D. moved to dismiss this case.
SECONDED: Ram R. Krishna, M.D
ROLL CALL VOTE was taken and the following members voted in favor of the motion: Patrick N. Connell, M.D., Ingrid E. Haas, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin III, M.D., Sharon B. Megdal, Ph.D., and Dona Pardo, Ph.D., R.N. The following Board members were recused from the motion: Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., and Edward J. Schwager, M.D. The following Board member was absent from the meeting: Ronnie R. Cox, Ph.D.
VOTE: 8-yay, 0-nay, 3-abstain/recuse, 1-absent
MOTION PASSED.

REHEARING MATTERS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
1.	MD-99-0398 03F-4729-MDX	AMB	JANICE M. PEARL, M.D.	4729	Advisory Letter. The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action; assess the cost of the formal hearing to Dr. Pearl.

Janice M. Pearl, M.D. appeared with legal counsel Kraig Marton. Edward J. Schwager, M.D., recused himself from this case. Hal Pittman, M.D., made a statement to the Board at the call to the public and found nothing in Janice M. Pearl, M.D.'s care of these patient's that fell below the standard of care.

Dr. Heller made a statement to the Board at the call to the public and stated that he has known Dr. Pearl for many years and having reviewed the many materials involving Dr. Pearl, is wondering why this case has come this far, as none of the cases had adverse outcomes.

Dr. Pearl made a statement to the Board. Dr. Pearl claimed that Mr. Wolf did not allow her to give her side of the story and only took the word of an attorney of the state of Idaho. Mr. Wolf has not heard of the praise that Dr. Pearl has received from past patients.

Kraig J. Marton stated that a rehearing should take place for this case because it is the right thing to do and legally the right thing to do. Mr. Marton also stated that this Board could not legally take action because there is no basis and the Board should not make a decision based on the amount of time that the Attorney General's office spends on a case.

Steve Wolf, Assistant Attorney General, made a statement to the Board on behalf of the state. Mr. Wolf informed the Board that he feels that having expert witnesses come before the Board to the call to the public is inappropriate. Mr. Wolf stated that Dr. Pearl has had three counts of negligence sustained in the highest court in Idaho and the Board should maintain the letter of reprimand or issue an advisory letter. Mr. Wolf also stated that the original sanction of a letter of reprimand is perfectly appropriate.

REHEARING MATTERS (Continued) - JANICE M. PEARL, M.D.

Robert P. Goldfarb, M.D., clarified with Mr. Wolf that there is a stipulation from the Idaho State Board of Medicine that Dr. Pearl be monitored. Dr. Goldfarb stated for the record that the amount of time that the Attorney General spends on a case has never been taken into consideration when making a decision before the Board as Mr. Marton suggested in his statement to the Board. Tim B. Hunter, M.D., stated that this case does not rise to the level of discipline. Christine Cassetta, Assistant Attorney General, confirmed that the Idaho State Board of Medicine's monitoring of Dr. Pearl's charts is a disciplinary action pursuant to Board statutes.

MOTION: Tim B. Hunter, M.D., moved to dismiss this matter.
The motion failed for lack of a second.

Christine Cassetta, Assistant Attorney General, informed the Board that they have already made a finding of unprofessional conduct and that the Board granted the rehearing solely to consider the applicable sanction. Patrick N. Connell, M.D., stated that this does not rise to the level of discipline and recommended issuing an advisory letter to Dr. Pearl.

MOTION: Patrick N. Connell, M.D., moved to issue an advisory letter. A.R.S. § 32-1401(3) - "Advisory Letter" means a non-disciplinary letter to notify a licensee that: (d) The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.
SECONDED: William R. Martin III, M.D.
VOTE: 6-yay, 4 nay, 1-abstain/recuse, 1-absent
MOTION PASSED.

MOTION: William R. Martin III, M.D., moved to assess the cost of the formal hearing to Dr. Pearl.
SECONDED: Douglas D. Lee, M.D.
VOTE: 9-yay, 1-Tim B. Hunter, M.D., 1-abstain/recuse, 1-absent
MOTION PASSED.

FORMAL INTERVIEWS (Continued)

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
2.	MD-02-0350A	AMB	ANTHONY T. YEUNG, M.D.	6424	Dismissed.

Anthony T. Yeung, M.D., appeared before the Board with his attorney Timothy Kasparek. William R. Martin III, M.D. and Ram R. Krishna, M.D., recused themselves from this matter.

William Kennell, M.D., Board Medical Consultant reviewed this case with the Board. The allegations in this case are that Dr. Yeung inappropriately performed a microdiscectomy on the patient removing significant amounts of nerve tissue; failed to advise the patient of the removal of significant amounts of nerve tissue during the microdiscectomy and that there could be significant and permanent nerve injury; discharged the patient from his care without advising the patient that the reason for the lack of improvement and continued pain and disability was the removal of this nerve tissue during the microdiscectomy; failed to adequately document the entire surgical procedure in the operative note; and inadequately documented the patient's post-operative neurological status.

Anthony T. Yeung, M.D., made a statement to the Board. Dr. Yeung stated that he documented the patient's complaint and after the exam noted that the patient fully recovered. Dr. Yeung stated that he takes very seriously any allegation of his patient care and asked that the Board dismiss this case.

Robert P. Goldfarb, M.D., presenting Board member began the questioning of Dr. Yeung. Dr. Yeung informed the Board that all records pertaining to this case were submitted to the Board and there are no further records. Dr. Yeung stated that a conjoint root is an anomalous nerve where two nerves will come out of the same location and at every disk level is usually one nerve. Dr. Yeung stated that the conjoint nerve root was not responsible for any of the patient's symptoms. Dr. Yeung was surprised to see the that the patient was doing badly and his summary of what happened is that there was a conjoint nerve root, but was not aware of this until the malpractice against him. Dr. Goldfarb stated that all three magnetic resonance images (MRI) were misread and all radiologists missed it. Dr. Yeung stated that after surgery the patient did not have any complaints. Dr. Yeung also stated that he sends all his specimens to Mark Kartub, M.D. Dr. Yeung stated that he is changing his practice to document further as he goes.

Timothy Kasparek made a statement to the Board on behalf of Dr. Yeung. Mr. Kasparek stated that the recommendation of the review committee is that the findings be dismissed for allegation number one. Mr. Kasparek urged the Board to dismiss this case. William Kennell, M.D., Board Medical Consultant, confirmed with the Board that allegation number one should be dismissed.

FORMAL INTERVIEWS (Continued) - ANTHONY T. YEUNG, M.D.
Dr. Goldfarb stated that he does not find that Dr. Yeung fell below the standard of care in surgery. Dr. Goldfarb also stated that one could say there was a lack of documentation, but there were a number of neurological examinations post operatively. Dr. Goldfarb recommended that this case be dismissed.

MOTION: Becky Jordan, moved to dismiss this case.
SECONDED: Tim B. Hunter, M.D.
ROLL CALL VOTE was taken and the following members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Tim B. Hunter, M.D., Becky Jordan, Douglas D. Lee, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N., and Edward J. Schwager, M.D. The following Board members were recused from the motion: Ram R. Krishna, M.D. and William R. Martin III, M.D. The following Board member was absent from the meeting: Ronnie R. Cox, Ph.D.
VOTE: 9-yay, 0-nay, 2-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
3.	MD-03-0560A		RICKY OCHOA, M.D. (RESIDENT)	Res. No. 81895	Terminate the Interim Order and issue a post-graduate training permit; Board staff to Draft Findings of Fact, Conclusions of Law and Order for Probation for five years with Monitored Aftercare Program (MAP) terms.

Ricky Ochoa, M.D., appeared before the Board without legal representation.

Kathleen Mueller, Monitored Aftercare Program coordinator, reviewed this case with the Board. The allegation in this case is that Dr. Ochoa's conduct was unprofessional when during his first week in a residency program he tested positive for cocaine on a routine urine drug screen.

Patrick N. Connell, M.D., presenting Board member began the questioning of Dr. Ochoa. Dr. Connell noted to Dr. Ochoa how serious the Board takes these matters.

The Board members questioned Dr. Ochoa. Dr. Ochoa stated that he graduated from the University of Arizona in Tucson and that his recovery is going well and he has been working closely with Dr. Sucher. Dr. Ochoa also stated that his fellow residents would be a big source of support for him along with his family.

Dr. Ochoa informed the Board that he has been clean and sober for 7 months and he will be and continue to be successful with recovery.

MOTION: Patrick N. Connell, M.D., moved to terminate the Interim order and issue a post-graduate training permit; Board staff to draft findings of fact, conclusions of law and order for probation for five years with monitored aftercare program (MAP) terms.
SECONDED: William R. Martin III, M.D.
ROLL CALL VOTE was taken and the following members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N., and Edward J. Schwager, M.D. The following Board member was absent from the meeting: Ronnie R. Cox, Ph.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
4.	MD-02-0744A	M.L.	ROY R. GETTEL, M.D.	11015	Dismissed.

Roy R. Gettel, M.D., appeared before the Board with his attorney Jack I. Redhair. Robert P. Goldfarb, M.D., noted that he has had a previous professional relationship with Mr. Redhair, but this will not affect his ability to adjudicate this case. Edward J. Schwager, M.D., stated that Mr. Redhair has previously consulted with him, but will not affect his ability to adjudicate this case.

Philip Scheerer, M.D., Board Medical Consultant reviewed this case with the Board. The allegations in this case are that Dr. Gettel failed to correctly interpret the x-ray of a knee; failed to review the radiologist's interpretation of this x-ray and follow through with the radiologist's recommendation in regard to a needle biopsy; delayed the diagnosis of osteosarcoma; and performed the wrong type of biopsy of this tumor.

Roy R. Gettel, M.D., made a statement to the Board. Dr. Gettel stated that he never viewed the x-rays from January 10, 2001 and requested those x-rays from the Board, but the Board did not have them either. Dr. Gettel stated that he discussed with the

patient all of the options for care, as the initial x-ray showed the post fracture changes of a supracondylar fracture of seven years prior. Dr. Gettel stated that the radiology report was sent to Dr. Shannon and was not available for his review. Dr. Gettel stated that the February 15 report arrived on February 21 and at that point there was a fracture to the lateral aspect of the femur. Dr. Gettel stated that a full work up was done because it looked as if cancer was inside as well as outside of the bone. Dr. Gettel stated that two weeks from the discovery of osteosarcoma to the treatment was not a significant delay due to the extensive testing and diagnosis. Dr. Gettel also stated that five or six specimens sent for diagnosis and an amputation was considered, but the pathologist was unable to make the diagnosis. Dr. Gettel stated that the incisional biopsy was absolutely necessary for this type of tumor.

William R. Martin III, M.D., presenting Board member began the questioning of Dr. Gettel. In response to Dr. Martin's questions Dr. Gettel stated that the abnormality was the position of the patella, but there were changes that occurred from a previous fracture. Dr. Gettel stated that there was a significant change in the patient's x-ray at a later date and it was then that Dr. Gettel was convinced that the patient had a tumor. Dr. Gettel stated that he recommended a bone scan, a magnetic resonance imaging (MRI) and a biopsy. Dr. Gettel informed the Board that when he refers a patient to another physician, he provides all the reports, but Dr. Shannon referred this patient to him and failed to provide him with the x-ray reports. Dr. Gettel stated that this patient had a very aggressive lesion that was a rare cancer.

The Board members questioned Dr. Gettel. Dr. Gettel clarified that the tumor was malignant, but the oncologist felt that they could get a good response with the treatment used. Dr. Gettel stated that with this type of tumor required an amputation. Dr. Gettel stated that he now follows up and receives a report before the x-rays enabling him to diagnose more accurately.

Mr. Redhair made a statement to the Board on behalf of Dr. Gettel. Mr. Redhair stated that the x-ray report went to Dr. Shannon, who referred the patient to Dr. Gettel, and failed to communicate the concerns to Dr. Gettel.

Dr. Martin stated that because the x-rays were not available to the Board the Board is unable to adjudicate the allegation of failing to interpret the x-ray of the knee, but because of the outcome, it would seem that the lesion would have been there. Nevertheless, allegation number two is tied into allegation number one and questioned how Dr. Gettel would have been able to follow through with something he was not privy to. Dr. Martin stated as far as allegation number three is concerned, if the diagnosis was made on January 19 or February 19, it would not have made a difference in the patient's outcome due to the type of disease. Dr. Martin recommended that the Board dismiss this case.

MOTION: William R. Martin III, M.D., moved to dismiss this case.
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE was taken and the following members voted in favor of the motion: Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N., and Edward J. Schwager, M.D. The following Board member voted against the motion: Patrick N. Connell, M.D. The following Board member was absent from the meeting: Ronnie R. Cox, Ph.D.
VOTE: 10-yay, 1-nay, 0-abstain/recuse, 1 absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
5.	MD-03-0273A	D.B.	SAADEH A. SAADEH, M.D.	27517	Dismissed.

Saadeh A. Saadeh, M.D., appeared before the Board without legal counsel.

Philip Scheerer, M.D., Board Medical Consultant reviewed this case with the Board. The allegations in this case are that Dr. Saadeh performed a coronary angiogram in a medical facility that did not have adequate equipment or supplies to safely manage a known high-risk patient and that Dr. Saadeh deceived the patient about having privileges at the Arizona Heart Institute-Phoenix, and did not obtain medical records from the patient's previous cardiologist.

Saadeh A. Saadeh, M.D., made a statement to the Board. Dr. Saadeh stated that the patient was a very knowledgeable person and knew every option available. Dr. Saadeh stated that he also advised the patient to quit smoking and performed a low level stress test. Dr. Saadeh stated that every option was reviewed with the patient then a left heart cardio catheterization was planned and it was then that he advised the patient that he had privileges at the Arizona Heart Hospital, but if the patient preferred, he could choose to be transferred to the Arizona Heart Institute in Phoenix. Dr. Saadeh stated that a chest x-ray was ordered that showed the patient had severe multi-vessel disease and that everything was hanging by a thread.

Edward J. Schwager, M.D., presenting Board member began the questioning of Dr. Saadeh. Dr. Saadeh reiterated that he did offer to the patient the option of going to Phoenix. Dr. Schwager inquired that the patient was fairly knowledgeable, but Dr. Saadeh was knowledgeable of the risk, so why would he have allowed this procedure to be performed in Lake Havasu, where

the proper equipment was not available? Dr. Saadeh stated that it was more convenient for the patient. Dr. Saadeh stated that the outcome would not have been any different if the procedure was performed in Phoenix or Lake Havasu. Dr. Saadeh transferred the patient immediately and did everything by the book when complications occurred.

The Board members questioned Dr. Saadeh. Dr. Saadeh stated that has had privileges at the Arizona Heart Hospital since July of 1999 along with privileges in Scottsdale. Dr. Megdal confirmed with staff that the allegation of privileges having privileges at the Arizona Heart Institute was not correct as Dr. Saadeh's privileges were at the Arizona Heart Hospital.

Edward J. Schwager, M.D., stated that on an overall basis this does not rise to the level of discipline, although there was poor judgment doing the procedure at Lake Havasu with a high-risk patient. Dr. Schwager stated this is more of a technical error. Dr. Schwager stated that Dr. Saadeh handled the complications well and recommended that the Board issue Dr. Saadeh an advisory letter for performing a cardiac catheterization on a high-risk patient in a peripheral heart catheterization lab.

MOTION: Edward J. Schwager, M.D., moved to issue an advisory letter for performing a cardiac catheterization on a high-risk patient in a peripheral heart catheterization lab. A.R.S. § 32-1401(3) - "Advisory Letter" means a non-disciplinary letter to notify a licensee that: (d) The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE was taken and the following members voted in favor of the motion: Patrick N. Connell, M.D., Ram R. Krishna, M.D., William R. Martin III, M.D., and Edward J. Schwager, M.D. The following Board member voted against the motion: Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Tim B. Hunter, M.D., Becky Jordan, Douglas D. Lee, M.D., Sharon B. Megdal, Ph.D., and Dona Pardo, Ph.D., R.N. The following Board member was absent from the meeting: Ronnie R. Cox, Ph.D.
VOTE: 4-yay, 7-nay, 0-abstain/recuse, 1-absent
MOTION FAILED.

Dr. Megdal questioned Dr. Kennell if this type of procedure was within the standard of care. Dr. Kennell stated that the outside Medical Consultant who reviewed this case for the Board, was a Phoenix cardiologist who is used to performing this type of procedure with a lot back up available and recommended that this procedure should not have been done on this type of individual due to the lack of back up. Dr. Megdal stated that she would support dismissal because of the lack of evidence that the physician made a judgment error. Douglas D. Lee, M.D. stated that the question is if it fell below the standard of care to perform these types of procedures in a remote area or in an area where back up could not be provided. Dr. Schwager stated that as part of the documentation provided by the complainant the verbiage spells out that only low risk individuals ought to be studied in free standing laboratories, which is what happened in this case, but it is not clear as an absolute criteria. Dr. Schwager stated that the Lake Havasu Medical Center did meet the minimum standard by the ability to provide revival equipment. Dr. Schwager stated that he recommended an advisory letter in this case because there is a question of the judgment by allowing the patient the choice of where the procedure would be performed with the type of health conditions the patient had. Robert P. Goldfarb, M.D., understands Dr. Schwager's decision, but may be in support of dismissal, as this is a matter of judgment and Dr. Saadeh did not use the best judgment, but was qualified to do the procedure and if this situation were to arise again he would hopefully do things differently. Dr. Goldfarb stated that Dr. Saadeh handled the case well in view of no clear-cut guidelines. Becky Jordan stated that it sounds like the patient really did not want to go to Phoenix and the Board needs to take the wishes of the patient into consideration and the patient wished to have the procedure performed in Lake Havasu.

MOTION: Robert P. Goldfarb, M.D., moved to dismiss this case.
SECONDED: Becky Jordan
ROLL CALL VOTE was taken and the following members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Tim B. Hunter, M.D., Becky Jordan, Sharon B. Megdal, Ph.D., and Dona Pardo, Ph.D., R.N. The following Board members voted against the motion: Ram R. Krishna, M.D., Douglas D. Lee, M.D., and Edward J. Schwager, M.D. The following Board member abstained from the motion: William R. Martin III, M.D. The following Board member was absent from the meeting: Ronnie R. Cox, Ph.D.
VOTE: 7-yay, 3-nay, 1-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
6.	MD-03-0286A	D.M.	KIANOUSH KIAN, M.D.	22618	Advisory Letter for not completing an examination of a patient. The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.

Kianoush Kian, M.D., appeared before the Board with his attorney Michael J. Ryan.

FORMAL INTERVIEWS (Continued) - KIANOUSH KIAN, M.D.

Rudolf Kirschner, M.D., Board Medical Consultant reviewed this case with the Board. The allegation in this case is that Dr. Kian initiated an eye examination, dilated the patient's eyes, and then left the office without completing the examination or informing the patient. The entire office staff then closed the office and left for the day, leaving the patient in the examining room with dilated eyes.

Dr. Kian made a statement to the Board. Dr. Kian stated that this did occur and he is sorry about it. Dr. Kian stated that there was no harm to the patient and he has changed his office procedures to ensure that this does not happen again.

Becky Jordan, presenting Board member, began the questioning of Dr. Kian. Dr. Kian stated that the patient was the last patient of the day and was at the end of the hallway with the door open. Dr. Kian stated that he has never heard of a patient who was unable to sleep due to dilated eyes as the complainant alleged and that a reaction would have occurred within 2-5 minutes of dilation.

The Board members questioned Dr. Kian. The Board members brought up an office form where Dr. Kian marked normal, but yet he did not finish the examination of the patient after dilation of the eyes because he left the office for an emergency. Dr. Kian responded that he completed the form when he was with the patient and stated that there would have been a five in one million chance of melanoma. Dr. Kian stated that the office personnel currently have in place procedures to check every room prior to closing. The Board members brought up that the fact that the patient's medical record was signed off and completed when in fact the examination was not completed.

Mr. Ryan made a statement to the Board on behalf of Dr. Kian. Mr. Ryan stated that Dr. Kian and his staff have now changed procedures. Mr. Ryan also stated that there was no harm to the patient and stated that the reason Dr. Kian left the office in the first place was because of an emergency of a friend in the hospital.

Ms. Jordan recommended that the Board dismiss this case, as this was a one-time occurrence and, according to the materials, Dr. Kian has seen 62,000 patients and, other than a feeling of abandonment, there was no harm to the patient.

MOTION: Becky Jordan moved for dismissal of this case.
The motion failed for lack of a second.

Tim B. Hunter, M.D., stated that he would support an advisory letter due to the fact that the patient was left in an examination room after office staff closed up. Edward J. Schwager, M.D., does not support an advisory letter and agrees with Ms. Jordan's motion for dismissal. Ram R. Krishna, M.D., stated that the advisory letter would be for not completing an examination of a patient. Sharon B. Megdal, Ph.D., stated that this was horrendous that a patient was left in a room and does not support an advisory letter or dismissal as Dr. Kian was in charge and had an obligation to care for the patient.

MOTION: Tim B. Hunter, M.D., moved to issue an advisory letter for not completing an examination of a patient. A.R.S. § 32-1401(3) - "Advisory Letter" means a non-disciplinary letter to notify a licensee that: (d) The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.
SECONDED: William R. Martin III, M.D.
ROLL CALL VOTE was taken and the following members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., William R. Martin III, M.D., and Sharon B. Megdal, Ph.D. The following Board member voted against the motion: Douglas D. Lee, M.D., Dona Pardo, Ph.D., R.N., and Edward J. Schwager, M.D. The following Board member was absent from the meeting: Ronnie R. Cox, Ph.D.
VOTE: 8-yay, 3-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
7.	MD-03-0230A	P.N.	KENNETH I. KLEIN, M.D.	10930	Advisory Letter for failure to diagnose a subacute subdural hematoma, as there were mitigating circumstances.

Kenneth I. Klein, M.D., appeared before the Board with his attorney Paul J. Giancola. Ingrid E. Haas, M.D., stated that she knows Paul J. Giancola, but this will not affect her ability to adjudicate this case.

Rudolf Kirschner, M.D., Board Medical Consultant reviewed this case with the Board. The allegation in this case is that Dr. Klein failed to provide appropriate follow-up care, including a repeat computed tomography (CT) scan for progressive neurological symptoms in an 84-year-old male with a known head injury.

FORMAL INTERVIEWS (Continued) - KENNETH I. KLEIN, M.D.

Kenneth I. Klein, M.D., made a statement to the Board. Dr. Klein stated that he is Board Certified in Geriatrics. Dr. Klein also stated that he was the family physician for both the patient and the complainant. Dr. Klein informed the Board that the patient had no neurological complaints.

Robert P. Goldfarb, M.D., presenting Board member began the questioning of Dr. Klein. Dr. Goldfarb asked Dr. Klein to explain why some office notes are typed and some are handwritten. Dr. Klein replied by explaining his method of charting. Dr. Klein stated that at the time of the first conversation with the patient's wife, who had concern about her husband, he was not concerned about the patient's memory and the patient being sleepy because these were concerns prior to the patient's accident. Dr. Klein stated that after the second phone call with the patient's wife he knew the patient was scheduled for a full physical the next day and relayed to the patient's wife that the patient had not had a stroke and told her to keep the appointment for the next day. Dr. Klein stated that he discussed depression with the patient and further testing was not done regarding the pain in the patient's shoulder. Dr. Goldfarb stated that the patient's wife called several times complaining that the patient was more confused, dizzy, moving slowly and blurred vision. Dr. Klein replied by stating that the symptoms explained by the wife were worrisome, but after examining the patient, he did not find anything wrong.

The Board members questioned Dr. Klein and brought up the fact that he states he gave the patient a neurological examination, yet this is not recorded in the patient's medical records. Dr. Klein stated that the charts in his office are assembled in a specific manner. Tim B. Hunter, M.D., stated that he would not be able to tell by picking up the patient's record that there was a neurological examination completed. Dr. Klein brought a poster size diagram of how his charts are assembled and reviewed this with the Board. Dr. Klein stated that each examination is completed on a separate sheet now. Patrick N. Connell, M.D., commented to Board staff that there is no rhyme or reason as to how documents are scanned into our system for the Board to review.

Mr. Giancola made a statement to the Board on behalf of Dr. Klein. Mr. Giancola stated that Dr. Klein examined the patient three times, observing him walk, talk, and move to determine what was happening with the patient. A neurological examination was done and everything was fine and the bottom line is that there was not a failure to diagnose this patient by Dr. Klein and there was no delay in the diagnosis and treatment of this patient.

Dr. Kirschner commented that the records would not be acceptable records.

Dr. Goldfarb stated that on the basis of the records of the emergency room, the patient did fall off of his bike and hit his head and shoulder and did have a laceration. Dr. Goldfarb stated that the wife showed concern and with the symptoms there might have been the development of a subdural hematoma in a hypertensive patient, however, Dr. Klein was the patient's physician for twenty plus years and the patient had not been in a stellar cognitive condition for some time. Dr. Goldfarb stated that there is some evidence here that shows that the physician failed to diagnose a subdural hematoma in violation of A.R.S. § 32-1401(26) - "Unprofessional conduct" includes the following, whether occurring in this state or elsewhere: (q) Any conduct or practice that is or might be harmful or dangerous to the health of the patient or public. Dr. Goldfarb stated that the mitigating circumstances are such to issue Dr. Klein an advisory letter for failure to diagnose a subdural hematoma and improve his record keeping.

MOTION: Robert P. Goldfarb, M.D., moved to issue an advisory letter for failure to diagnose a subdural hematoma and improve his record keeping, as there were mitigating circumstances.
The motion failed for lack of a second.

Dr. Hunter stated that the record keeping leaves a lot to be desired, but the physician was not noticed for that. Dr. Hunter stated that he would support dismissal, as there was no good evidence that the physician missed the diagnosis of a subdural hematoma. Edward J. Schwager, M.D., would support dismissal also, and although the physician's records are unique and are difficult to follow, as noted by Dr. Hunter, the physician was not noticed for this violation. Dr. Schwager stated that Dr. Klein did review this patient's medical history with the emergency room physician and that physician noted that it was Dr. Klein who was the one that recommended further testing be done. Ram R. Krishna, M.D., stated that he would not support dismissal because of the clinical symptoms that the patient had all along and something should have been done sooner, meaning that Dr. Klein dropped the ball. William R. Martin III, M.D., commented that there were other things brought out in the testimony such as the wife's suggestion of a stroke and the fall and weakness in the patient's leg that would lead someone to believe that something more was wrong. Dr. Krishna stated that the patient should have been seen sooner, but questioned when that could have been done. Dr. Connell commented that the findings from an examination of an elderly patient are different then that of a younger patient and due to the phone calls from the wife, her concerns should have been addressed. Dr. Connell stated that he would not support dismissal. Dr. Schwager stated that in terms of an issue one could say the patient should have been evaluated that day, but does not see enough information in the records that this would rise to the level of discipline. Dr. Goldfarb stated that subdural hematomas do wax and wane. Douglas D. Lee, M.D. commented that the question is why was the CT scan not done? Dr. Hunter recommended that this case be dismissed because there was not good evidence that the physician missed the subdural hematoma.

FORMAL INTERVIEWS (Continued) - KENNETH I. KLEIN, M.D.

MOTION: Tim B. Hunter, M.D., moved to dismiss this case.
SECONDED: Edward J. Schwager, M.D.
ROLL CALL VOTE was taken and the following members voted in favor of the motion: Tim B. Hunter, M.D., Dona Pardo, Ph.D., R.N., and Edward J. Schwager, M.D. The following Board member voted against the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin III, M.D., and Sharon B. Megdal, Ph.D. The following Board member was absent from the meeting: Ronnie R. Cox, Ph.D.
VOTE: 3-yay, 8-nay, 0-abstain/recuse, 1-absent
MOTION FAILED.

MOTION: Robert P. Goldfarb, M.D., moved to issue an advisory letter for failure to diagnose a subacute subdural hematoma, as there was mitigating circumstances.
SECONDED: William R. Martin III, M.D.
ROLL CALL VOTE was taken and the following members voted in favor of the motion: Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Becky Jordan, Douglas D. Lee, M.D., William R. Martin III, M.D., and Sharon B. Megdal, Ph.D. The following Board member voted against the motion: Patrick N. Connell, M.D., Tim B. Hunter, M.D., Dona Pardo, Ph.D., R.N., and Edward J. Schwager, M.D. The following Board member abstained from the motion: Ram R. Krishna, M.D. The following Board member was absent from the meeting: Ronnie R. Cox, Ph.D.
VOTE: 6-yay, 4-nay, 1-abstain/recuse, 1-absent
MOTION PASSED.

NON-TIME SPECIFIC ITEMS

EXECUTIVE DIRECTOR'S REPORT

Staff Reports

Compliance Modification/Termination of Board Orders

Wendy Nicholson, Senior Compliance Officer, informed the Board that a physician under Board Order can request modification at any time and stated the Board's Compliance staff is requesting that the Board require a physician to be in compliance and serve half of the probation prior to requesting modification or termination. The Board members discussed the details of this issue. Mike Zakrzewski, Senior Compliance Officer, informed the Board that the suggested guidelines mirror the State of California Medical Board guidelines. The Board members concluded that an off-site meeting was needed to discuss this issue.

LEGISLATIVE REPORT

Tina Wilcox, Board Legislative Liaison, updated the Board members regarding the bills currently before the Legislature. Ms. Wilcox stated that the Legislature has stalled the progress of the Board's bill and is not comfortable supporting the proposed Physician Health Program until the current Board audit is made public. Sharon B. Megdal, Ph.D., stated that this item has not been placed on the agenda for possible action and inquired if the Board has the ability to make certain decisions. Christine Cassetta, Assistant Attorney General, stated that when the original bills were voted on the Board gave Ms. Wilcox general authority to shepherd the Board's bills and programs through, but the Board could meet on this issue for further clarification. Dr. Megdal noted that this is not a small change, but an entirely new packet. Ms. Wilcox noted that she and Dr. Cassidy had met with Dr. Connell to discuss the changes made to the program. Dr. Hunter voiced his concerns about changes to the bill because he supported the bill specifically because only self-reports were to be confidential and now that appears to have changed.

APPROVAL OF MINUTES

January 14, 2004 Teleconference Meeting

Christine Cassetta, Board Counsel, informed the Board of her suggested changes including, page 2 change "the malpractice case" to "one of the malpractice cases", remove "made a statement before the Board on behalf of the State" from pages 4 and 5.

MOTION: Ram R. Krishna, M.D., moved to approve the regular minutes with the changes as suggested above and the executive session minutes.
SECONDED: Robert P. Goldfarb, M.D.
VOTE: 10-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
1.	MD-03-0878B	K.S.	DENNIS M. HUGHES, M.D.	25310	Uphold the Executive Director's dismissal.
2.	MD-02-0797A	W.T.	M. BRIGID CONNOLLY, M.D.	17081	Uphold the Executive Director's dismissal.
3.	MD-03-0486A	B.W.	MATTHEW BORST, M.D.	20785	Uphold the Executive Director's dismissal.

NON-TIME SPECIFIC ITEMS (Continued) - MATTHEW BORST, M.D.

Matthew Borst, M.D., made a statement to the Board at the call to the public. Dr. Borst stated that the patient had a significant number of risk factors and when the problem of fistula came about, surgical care was immediately provided. Dr. Borst stated that the Radiologist Oncologist determined that the patient could not tolerate radiation therapy and a radical hysterectomy, therefore was not recommended for this patient. Dr. Borst requested that the Board review the materials he distributed.

B.W. made a statement to the Board at the call to the public. B.W. informed the Board that after his wife's surgery, the surgeons were able to remove everything and there was no need for chemotherapy or radiation. B.W. stated that they were never informed that radiation or chemotherapy were options to consider; several months later a stage 4 tumor was found on her bladder and his wife passed away. B.W. stated that Dr. Borst never visited them regarding his wife's illness.

L.E. made a statement to the Board at the call to the public. L.E. stated that her mother had been hospital many times. L.E. stated that her mother did not die from hypertension or diabetes, but from the cancer that metastasized, after Dr. Borst informed that them that he was able to remove the cancer.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
4.	MD-03-0346A	L.S.	CHARLES I. HECHT, M.D.	11951	Uphold the Executive Director's dismissal.

Case number 4 was pulled for individual consideration. William R. Martin III, M.D., made a comment on the letter from the complainant and stated that it was very strong. Edward J. Schwager, M.D., stated that the patient did a fair amount of her own research and the recommended procedure was not the large lumpectomy, but that was what she wanted and the patient did not get a good cosmetic result. Dr. Martin stated that the complainant was concerned about the gruesome result and that this case should be further investigated. Beatriz Garcia Stamps, M.D., M.B.A., Medical Director, referred to the supplemental medical consultant report.

MOTION: William R. Martin III, M.D., moved to overturn the Executive Director's dismissal and continue this case.
The motion failed for lack of a second.

MOTION: Ram R. Krishna, M.D., moved to uphold the Executive Director's dismissal of this matter.
SECONDED: Patrick N. Connell, M.D.
VOTE: 10-yay, 1-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
5.	MD-03-0709A	M.R.	ARNOLD B. MERIN, M.D.	11084	Uphold the Executive Director's dismissal.

Edward J. Schwager, M.D., and Tim B. Hunter, M.D., recused themselves from this matter.

Dr. Merin made a statement to the Board at the call to the public. Dr. Merin handed materials to the Board. Dr. Merin stated that perforation of the colon is a known risk and he informed the patient of this. Dr. Merin also stated that his focus was on removing the two-centimeter polyp and he was also concerned that it was cancerous. Dr. Merin informed the Board that he provided the appropriate standard of care and that the allegations against him are not supported.

M.R. made a statement to the Board at the call to the public. M.R. stated that he believes the perforation of the colon was due to the polyp removal and that the May 18 report was relevant due to the findings given by Dr. Merin that may have been written after the surgery. M.R. stated that Dr. Merin's recommendation was to follow up with a biopsy and that Dr. Merin ordered several tests that should have shown the seriousness of her illness. M.R. stated that this error was not intentional, but was due to the carelessness of Dr. Merin. M.R. questioned if her recovery could have been shortened with the treatment of antibiotics.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
6.	MD-03-1047A	D.W.	SOMAN P. PHILIP, M.D.	28071	Uphold the Executive Director's dismissal.
7.	MD-03-0815A	M.G.	RICHARD L. AVERITTE, JR, M.D.	30247	Uphold the Executive Director's dismissal.
8.	MD-03-0573A	A.S.	ROBERT H. TAMIS, M.D.	4044	Uphold the Executive Director's dismissal.
9.	MD-03-0877B	B.E.	AMY C. RICO, M.D.	27737	Uphold the Executive Director's dismissal.
10.	MD-03-1112A	L.S.	JAMES R. MOUER, M.D.	6183	Uphold the Executive Director's dismissal.

L.S. made a statement to the Board at the call to the public. L.S. informed the Board of her misery over the years caused by James R. Mouer, M.D.

NON-TIME SPECIFIC ITEMS (Continued) - JAMES R. MOUER, M.D.

James R. Mouer, M.D., made a statement to the Board at the call to the public. Dr. Mouer informed the Board that the allegation in this case happened more than 29 years ago and stated that, because of the passage of time, he was unable to locate this patient's records. Dr. Mouer informed the Board that the only thing connecting him with this patient is that his name was on a baby band, that he has no recollection of the patient, and that she has indicated that he may not be the physician that performed the procedure.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
11.	MD-03-0821A	R.P.	SIMRANJIT S. GALHOTRA, M.D.	27506	Uphold the Executive Director's dismissal.
12.	MD-03-0463A	R.U.	ABHAY SANAN, M.D.	27663	Uphold the Executive Director's dismissal.

D.U. made a statement to the Board at the call to the public on behalf of R.U.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
13.	MD-03-0828A	I.R.	JOHN QUIGLEY, M.D.	20243	Uphold the Executive Director's dismissal.
14.	MD-03-0066B	L.H.	A. NICHOLAS AWAD, M.D.	20281	Uphold the Executive Director's dismissal.

Tim B. Hunter, M.D., recused himself from this matter. L.H. made a statement to the Board at the call to the public. L.H. informed the Board of her stage 2 Breast Cancer, and that she had throat cancer in previous years. L.H. stated that Dr. Awad missed the tumor on her left lobe after viewing her X-rays. L.H. stated that a metastatic carcinoma was found that had spread to her chest wall, which was non-operable, and since her report to the Board, she has been diagnosed with stage 4-lung cancer. L.H. believes this was a cover up to hide her original misdiagnosis. L.H. stated that her physician informed her that her stage 4-lung cancer is slow growing and it would have been operable.

Attorney Jay Fradkin made a statement to the Board at the call to the public on behalf of Dr. Awad and requested that the Board uphold the Executive Director's dismissal. Mr. Fradkin asked that the Board review all documents in this case.

MOTION: Ram R. Krishna, M.D., moved to uphold the Executive Director's dismissal.
SECONDED: Patrick N. Connell, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
15.	MD-03-0700A MD-03-0700B MD-03-0700C MD-03-0700D	T.K.	PATRICIA A. STAPLER, M.D. JAMES W. BAIRD, M.D. JOHN T. O'STEEN, M.D. TERRELL C. MORITZ, M.D.	13309 28720 12389 20323	Uphold the Executive Director's dismissal.
16.	MD-03-0425B	M.V.	TERRY E. MCLEAN, M.D.	18855	Uphold the Executive Director's dismissal.

William R. Martin III, M.D., recused himself from this matter.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
17.	MD-03-0013A	S.D.	RICHARD A. SNIDER, M.D.	15303	Uphold the Executive Director's dismissal.
18.	MD-03-0664A	S.B.	MICHAEL T. LEE, M.D.	22408	Uphold the Executive Director's dismissal.

S.B. made a statement to the Board at the call to the public. S.B. stressed to the Board the poor aftercare due the fact that Dr. Lee did not listen to what she was saying. S.B. stated that Dr. Lee never examined her during any of her office visits with him nor did Dr. Lee return her calls. S.B. stated that she was in continual pain, but was told by Dr. Lee that she needed to exercise more. S.B. stated that she went to another physician who diagnosed her correctly within five minutes.

B.B. made a statement to the Board at the call to the public. B.B. informed the Board of his conversation with Dr. Lee after his wife's surgery and after months of pain after her surgery, Dr. Lee informed S.B. and B.B. that the reason for S.B.'s pain was due to arthritis that could be treated by shock remedies and steroids. B.B. stated that the issue here is psychological damage due to emotional stress.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
19.	MD-03-0926A	V.C.	JENNIFER D. CAMERON, M.D.	30064	Uphold the Executive Director's dismissal.
20.	MD-03-0791A	M.W.	EVA B. MCCULLARS, M.D.	20375	Uphold the Executive Director's dismissal.

NON-TIME SPECIFIC ITEMS (Continued) - EVA B. MCCULLARS, M.D.
M.R. made a statement to the Board at the call to the public. M.R. stated that she was mislabeled, misdiagnosed, and overmedicated to the point of physical illness from the side effect of the medications. M.R. stated that these false diagnoses were put on public record, which is now against the Health Insurance Portability and Accountability Act rules. M.R. stated that her car accidents have caused injury to her spine and post traumatic stress disorder.

MOTION: Becky Jordan moved to uphold the Executive Director's dismissal in cases 1 through 24, except cases 4, 14, and 21 through 24 which were pulled from the block vote for individual consideration.
SECONDED: Douglas D. Lee, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
21.	MD-03-1246A	J.C.	JOSEPH M. MILLER, M.D.	20168	Uphold the Executive Director's dismissal.

Case number 21 was pulled from the block vote for individual consideration.

MOTION: Patrick N. Connell, M.D., moved to uphold the Executive Director's dismissal.
SECONDED: Dona Pardo, Ph.D., R.N.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
22.	MD-03-0334A	B.E.	CHETANKUMAR C. PATEL, M.D.	20138	Uphold the Executive Director's dismissal.

Case number 22 was pulled from the block vote for individual consideration. Tim B. Hunter, M.D., stated that there seems to have been a delay in treating the patient's breast cancer and stated there may be some substance to it.

Philip Scheerer, M.D., Board Medical Consultant reviewed this case with the Board and stated that because of the discrepancy Dr. Patel came in for an interview and he stated that the patient never mentioned anything about her breasts and he never did a pelvic exam. Dr. Patel refers his patient's to an OB/GYN for breast and pelvic exams. Dr. Haas commented that the patient was seen by a nurse practitioner and a breast exam was done.

MOTION: Patrick N. Connell, M.D., moved to uphold the Executive Director's dismissal.
SECONDED: Ram R. Krishna, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
23.	MD-03-0419A MD-03-0419B	A.R.	SUSAN M. HALLMAN, M.D. ROLAND M. COUCHE, M.D.	21460 10023	Uphold the Executive Director's dismissal.

Case number 23 was pulled from the block vote for individual consideration. A.R. made a statement to the Board at the call to the public. A.R. wants questions answered due to the dismissal letter that she received.

Attorney Robin Burgess made a statement to the Board at the call to the public on behalf of Roland M. Couche, M.D. Ms. Burgess stated that A.R. did not intend to appeal the Executive Director's dismissal of Dr. Couche.

MOTION: Robert P. Goldfarb, M.D, moved to uphold the Executive Director's dismissal.
SECONDED: Dona Pardo, Ph.D., R.N.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
24.	MD-03-0247A	M.F.	AMANDEEP S. SODHI, M.D.	24427	Uphold the Executive Director's dismissal.

Case number 24 was pulled from the block vote for individual consideration. M.F. made a statement to the Board at the call to the public. M.F. asked the Board if they are inert or proactive. M.F. stated that he submitted the same complaint to the Health Service Advisory Group and will have an industry comparison with the Arizona Medical Board regarding the outcome. M.F. informed the Board that Amandeep S. Sodhi, M.D. did not come to M.F.'s mother when she was in need of immediate care.

Ram R. Krishna, M.D., stated that he was concerned about the delay in treatment for heart failure and that the patient was never seen by the pulmonologist. Dr. Krishna stated that the patient had a hip fracture and was transferred to a rehabilitation facility.

NON-TIME SPECIFIC ITEMS (Continued) - AMANDEEP S. SODHI, M.D.
MOTION: Edward J. Schwager, M.D., moved to uphold the Executive Director's dismissal.
SECONDED: Patrick N. Connell, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
25.	MD-03-L038A	L.I.	DAVID M. BAROFF, M.D.	N/A	Uphold the Executive Director's denial of licensure.

Case number 25 was pulled from the block vote for individual consideration. William R. Martin III, M.D., was not present when this matter was discussed. Diane Jones, Senior Licensing Investigator reviewed this case with the Board. Ms. Jones stated that she informed Dr. Baroff that his application could not be processed due to an open investigation with another state Board. Ms. Jones also stated that at a later time, she re-checked the Ohio Medical Board and found that Dr. Baroff's license was revoked. Ms. Jones stated that when Dr. Baroff was notified that the Executive Director denied his license application he appealed the denial.

Dr. Schwager stated that there is no statutory basis to rescind the denial of licensure.

MOTION: Tim B. Hunter, M.D., moved to uphold the Executive Director's denial of licensure.
SECONDED: Sharon B. Megdal, Ph.D.
VOTE: 10-yay, 0-nay, 0-abstain/recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
26.	MD-02-0478A	AMB	DWIGHT C. LUNDELL, M.D.	6960	Denied Motion for Rehearing or Review.

William R. Martin III, M.D. and Ram R. Krishna, M.D., were not present when this matter was discussed. The Board members stated that Ms. Hendrix's statements submitted to the Board were creative, but not convincing.

MOTION: Sharon B. Megdal, Ph.D., moved to deny the motion for rehearing or review.
SECONDED: Patrick N. Connell, M.D.
VOTE: 9-yay, 0-yay, 0-abstain/recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
27.	MD-01-0861	AMB	MARVIN L. GIBBS, JR., M.D.	13736	Refer to Formal Hearing.

William R. Martin III, M.D., was not present when this matter was discussed. Marvin L. Gibbs, Jr., M.D. made a statement to the Board at the call to the public. Dr. Gibbs stated that he has learned his lesson regarding Internet Consulting after attending the medical ethics and physician-prescribing course. Dr. Gibbs asked the Board, in lieu of removing the license restriction, that he be able to submit a copy of any prescription written for review by the Board. Dr. Gibbs stated that he is currently unable to get hospital privileges and this is also affecting his medical malpractice insurance rates.

Farshad Agahi, M.D. also made a statement to the Board at the call to the public on behalf of Dr. Gibbs. Dr. Agahi stated that the restriction on his license is preventing Dr. Gibbs from obtaining employment.

Wendy Nicholson, Senior Compliance Officer, reviewed this case with the Board. Ms. Nicholson stated that Dr. Gibbs claimed he has no office to work in, yet he is currently practicing in an office. Ms. Nicholson also stated that Dr. Gibbs has not paid the $10,000.00 civil penalty to date.

Beatriz Garcia Stamps, M.D., M.B.A., Medical Director, referred the Board to the medical consultant report where Dr. Barrick's reported that there are two inconsistencies. Dr. Stamps stated that the referral to formal hearing is in regards the Dr. Gibbs record keeping. Dr. Stamps also stated that the physician requested the modification of Board Order.

MOTION: Sharon B. Megdal, Ph.D., moved to deny the request of modification of board order.
SECONDED: Patrick N. Connell, M.D.
VOTE: 9-yay, 0-nay, 1-abstain/recuse, 2-absent
MOTION PASSED.

Patrick N. Connell, M.D., stated that there are issues in this case that would need to come out in a formal hearing.

NON-TIME SPECIFIC ITEMS (Continued) - MARVIN L. GIBBS, JR., M.D.
MOTION: Patrick N. Connell, M.D., move to refer this case to formal hearing.
SECONDED: Ram R. Krishna, M.D.
VOTE: 10-yay, 0-nay, 0-abstain/recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
28.	MD-02-0318A	AMB	STEVEN R. OTTO, M.D.	13323	Letter of Reprimand for failure to provide informed consent for the type of surgical incision for a planned repeat surgery with the patient and for failure to arrange adequate coverage when he was away and unavailable to take calls from his patients.

Becky Jordan and William R. Martin III, M.D., were not present when this matter was discussed. Sharon B. Megdal, Ph.D., would support placing on a future agenda the issue of civil penalties included in the consent agreements. The Board members discussed the issue of consistency using civil penalties. Dr. Schwager stated that this matter would be placed on the April agenda to be discussed, as it is not on the agenda to be discussed at this meeting. The Board members brought up the issue of anonymous complaints. Christine Cassetta, Board Counsel, stated that Board staff is addressing this issue and these complaints will be available to the Board members at the next meeting.

MOTION: Robert P. Goldfarb, M.D., moved to accept the proposed consent agreement as written.
SECONDED: Patrick N. Connell, M.D.
ROLL CALL VOTE was taken and the following members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Tim B. Hunter, M.D., Ram R. Krishna, M.D., Douglas D. Lee, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N., and Edward J. Schwager, M.D. The following Board members were not present when this matter was discussed: Becky Jordan and William R. Martin III, M.D. The following Board member was absent from the meeting: Ronnie R. Cox, Ph.D.
VOTE: 9-yay, 0-nay, 0-abstain/recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
29.	MD-03-0414A	AMB	JAMES T. CANAVAN, M.D.	19964	Not return to the clinical practice of anesthesiology until the Board affirmatively approves his return to such practice; Not apply for such approval for a minimum of 2 years from the March 9, 2003 date of entry into the treatment at the Betty Ford Center; Probation for five years.

William R. Martin III, M.D., was not present when this matter was discussed. The Board members stated that the Order states that the physician can practice pain management, but not handle controlled substances, but most pain medicine specialists prescribe controlled substances and order narcotic medications. The Board members also stated that the Board Order should say that the physician is not allowed to engage in practice until something happens versus shall not return. Christine Cassetta, Board Counsel, explained to the Board why the consent agreement was written in the order that it was. The Board members deliberated on the details of this case regarding allowing the physician to practice pain management and the practice setting.

MOTION: Tim B. Hunter, M.D., moved to accept the proposed consent agreement as written.
SECONDED: Patrick N. Connell, M.D.
ROLL CALL VOTE was taken and the following members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N., and Edward J. Schwager, M.D. The following Board member was not present when this matter was discussed: William R. Martin III, M.D. The following Board member was absent from the meeting: Ronnie R. Cox, Ph.D.
VOTE: 10-yay, 0-nay, 0-abstain/recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
30.	MD-02-0716A MD-02-0310A	AMB	MARK P. SALERNO, M.D.	25300	Terminate Interim Consent Agreement; Probation until further Order of the Board; may request Termination of Probationary Terms A (Limited Practice) and B (Group Practice) after five years from the effective date of the Consent Agreement.

NON-TIME SPECIFIC ITEMS (Continued) - MARK P. SALERNO, M.D.

The Board members discussed that five years of probation is not sufficient, as the physician is unstable due to a severe medical ailment and it is the Board's responsibility to protect the public. Sharon B. Megdal, Ph.D., recommended a ten-year probation, but would prefer an indefinite probation. Christine Cassetta, Board Counsel, confirmed with the Board members that they could impose probation until further Order of the Board in a Consent Agreement if the physician agreed. Ms. Cassetta clarified that the Board's intention is that the medical review and the psychiatric review continue indefinitely with the opportunity to request early termination after five years. Patrick N. Connell, M.D., stated that a provision would be needed for the physician to continue his psychiatric supervision quarterly reports indefinitely until such a time as his psychiatrist indicates that he no longer needs psychiatric care and is approved by the Board. Ms. Cassetta clarified that limited practice in group practice is for five years and the remaining terms will, if Dr. Salerno agrees, be indefinite with the ability to modify after five years and, if he accepts these terms, the Board will not need to see the agreement again.

MOTION: Sharon B. Megdal, Ph.D., moved to terminate the interim consent agreement; probation until further Order of the Board; may request termination of probationary terms A (Limited Practice) and B (Group Practice) after five years from the effective date of the consent agreement.
SECONDED: Patrick N. Connell, M.D.
ROLL CALL VOTE was taken and the following members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N., and Edward J. Schwager, M.D. The following Board member was not present when this matter was discussed: William R. Martin III, M.D. The following Board member was absent from the meeting: Ronnie R. Cox, Ph.D.
VOTE: 10-yay, 0-nay, 0-abstain/recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
31.	MD-02-0676B	AMB	ROBERT SCHWARTZSTEIN, M.D.	22481	Letter of Reprimand for failing to timely order blood replacement and failing to place the central venous lines for blood transfusion and properly respond to hypovolemia; $1,000.00 Civil Penalty

Becky Jordan and William R. Martin III, M.D., were not present when this matter was discussed.

MOTION: Patrick N. Connell, M.D., moved to accept the proposed consent agreement as written.
SECONDED: William R. Martin III, M.D.
The following Board members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Tim B. Hunter, M.D., Ram R. Krishna, M.D., Douglas D. Lee, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N., and Edward J. Schwager, M.D. The following Board members were not present when this matter was discussed: Becky Jordan and William R. Martin III, M.D. The following Board member was absent from the meeting: Ronnie R. Cox, Ph.D.
VOTE: 9-yay, 0-nay, 0-abstain/recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
32.	MD-03-0422A	R.L.	RICHARD G. BOTTIGLIONE, M.D.	14927	Dismissed.
33.	MD-03-0657B MD-03-0645C MD-03-0662A MD-03-0730C MD-03-0660A	AMB	MARK IVEY, M.D. LISA M. YORK, M.D. LISA M. YORK, M.D. LISA M. YORK, M.D. LAWRENCE D. COSS, M.D.	10659 24012 24012 24012 13791	Dismissed.

William R. Martin III, M.D., was not present when this matter was discussed.

MOTION: Ram R. Krishna, M.D., move to dismiss case number 32 and 33.
SECONDED: Patrick N. Connell, M.D.
VOTE: 10-yay, 0-nay, 0-abstain/recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
34.	MD-02-0675A	AMB	ROY R. GETTEL, M.D.	11015	Decree of Censure for failing to timely secure an urgent vascular consultation for the clinical signs and symptoms of circulatory compromise.

NON-TIME SPECIFIC ITEMS (Continued) - ROY R. GETTEL, M.D.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
35.	MD-02-0571A	AMB	CLARENCE E. RODRIGUEZ, M.D.	14409	Letter of Reprimand for failure to appropriately follow-up and treat a ventilator dependent nursing care center patient.
36.	MD-03-0085A	AMB	JOHN QUIGLEY, M.D.	20243	Letter of Reprimand for inadequate monitoring of the patient's ventilatory respiratory status during the last part of a plastic surgery procedure and for inadequately documenting that status from the last part of the procedure
37.	MD-02-0707A	AMB	SHAIN A. CUBER, M.D.	26775	Letter of Reprimand for failure to properly perform an ulnar nerve repair.
38.	MD-02-0426A	AMB	KATHLEEN K. FRY, M.D.	15481	Letter of Reprimand for failure to perform the operative procedure recommended to the patient and consented to by the patient and for performing a surgical procedure that was not medically necessary; $1,000.00 Civil Penalty.
39.	MD-03-0003A	R.S.	RANDALL P. SCOTT, M.D.	27944	Letter of Reprimand for failure to diagnose diabetes in the face of classic symptoms; Probation for one year.

MOTION: Ram R. Krishna, M.D., moved to adopt the draft findings of facts and conclusions of law and order for case numbers 34 through 39 as written.
SECONDED: Patrick N. Connell, M.D.
ROLL CALL VOTE was taken and the following members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N., and Edward J. Schwager, M.D. The following Board member was not present when this matter was discussed: William R. Martin III, M.D. The following Board member was absent from the meeting: Ronnie R. Cox, Ph.D.
VOTE: 10-yay, 0-nay, 0-abstain/recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
40.	MD-03-0826A	AMB	MARTIN L. MEYERS, M.D.	27917	Bifurcate the two issues (violation of Board Order and Consideration of Rational Recovery) and limit the Formal Interview to the violation of Board Order and have the Diversion Committee review the issue of Rational Recovery and other Programs and report back to the Board.

William R. Martin III, M.D., was not present when this matter was discussed. Martin L. Meyers, M.D., made a statement to the Board at the call to the public. Dr. Meyers informed the Board that he is committed to recovery and working with the Board to achieve this recovery.

Attorney Robert Milligan made a statement to the Board at the call to the public on behalf of Dr. Meyers. Mr. Milligan informed the Board that it is the most appropriate body to evaluate treatment options.

Materials regarding rational recovery will not be considered at the formal interview with Dr. Meyers.

MOTION: Edward J. Schwager, M.D., moved to bifurcate the two issues and limit the formal interview to the violation of the Board Order and have the diversion committee review the issue of rational recovery and other programs and report back to the Board.
SECONDED: Patrick N. Connell, M.D.
VOTE: 10-yay, 0-nay, 0-abstain/recuse, 2-absent
MOTION PASSED.

The meeting adjourned at 6:37 p.m.

FRIDAY, FEBRUARY 13, 2004

CALL TO THE PUBLIC

Edward J. Schwager, M.D., Chair, called the meeting to order at 8:07 a.m.

ROLL CALL

The following Board members were present: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin III, M.D., Dona Pardo, Ph.D., R.N., and Edward J. Schwager, M.D. The following Board member arrived late to the meeting: Sharon B. Megdal, Ph.D. The following Board member was absent from the meeting: Ronnie R. Cox, Ph.D.

CALL TO THE PUBLIC

Statements issued during the call to the public appear beneath the case referenced.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
1.	MD-02-0746A	AMB	HAROLD N. WALGREN, M.D.	15798	Advisory Letter for failing to alert the referring physician to the seriousness of the patient's problem and for failing to follow up with the patient. The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.

Harold N. Walgren, M.D., appeared before the Board with his attorney Paul Forrest. Sharon B. Megdal, Ph.D., was not present when this matter was discussed.

Robert Barricks, M.D., Board Medical Consultant reviewed this case with the Board. The allegation in this case is that Dr. Walgren failed to order additional ultrasound and/or spot films to further study a clinically palpable right breast mass in a high-risk 28-year-old female with a highly suspicious diagnostic mammogram. Instead, Dr. Walgren ordered a six-month follow up, at which time a Stage III malignancy was diagnosed with 9 out of 18 positive lymph nodes.

Tim B. Hunter, M.D., presenting Board member began the questioning of Dr. Walgren. The Board viewed the images of the patient. After viewing the images, Dr. Hunter pointed out a mass that should have been mentioned, but the images are copies and the date did not come through so there is no way to know the date of the images. Dr. Hunter stated that red flags should have been raised when there are calcifications in one breast, but not the other. Dr. Walgren stated he did try to convey this in his report. Dr. Hunter asked why Dr. Walgren did not do cone views and also asked why an ultrasound was not done. Dr. Walgren stated that he cannot recall his exact words, but there was no dominant mass, which is different than saying there is no mass. Dr. Walgren attempted to report that this is an abnormal finding to a very senior experienced surgeon. Dr. Hunter stated that he was concerned that nothing was done at that time, although the actual findings could be argued that sometimes you cannot see them, but why was further testing not done. Dr. Walgren stated that now the general practice is that upon finding a mass he would recommend further testing, but in the late 1990's that was not the procedure. Dr. Walgren also stated that the quality of the equipment available today was not available at that time.

The Board members questioned Dr. Walgren. The Board members inquired of Dr. Walgren as to what his methodology was when he would communicate to the referring physician the need for further testing. Dr. Walgren stated he would add to his report that additional films could also be done. The Board members asked Dr. Walgren what he would do for further evaluation if he were to find fibrous tissue in the breast. Dr. Walgren stated that he would follow up filming in a short interval, which would be approximately three to six months, but also stated that you should not to turn your back on a palpable mass.

Mr. Forrest made a statement to the Board on behalf of Dr. Walgren. Mr. Forrest stated that mammography is currently the biggest area of malpractice. The issue of self-referral or the collaboration should have occurred, but a letter of reprimand and a $1000.00 civil penalty is too high. Mr. Forrest stated that this was a case that did deserve a more aggressive phone call at some point, but was that type of procedure being done at that time.

Dr. Hunter stated that Dr. Walgren has good intentions and is probably a competent mammographer. Dr. Hunter also stated that Dr. Walgren should have done an ultrasound or contacted the physician, but the outcome most likely would not have changed anyway. Dr. Hunter stated that this does fall below the standard of care and does rise to the level of discipline.

Edward J. Schwager, M.D., stated that the issue in care is a systems process and as part of the system the question becomes the aggressiveness of the follow up. Dr. Schwager stated that this was unprofessional conduct, but does deserve an advisory letter because on an overall basis we depend on our diagnostic radiologist with issues of diagnosis and follow up, but it is the physician's decision to follow up. Tim B. Hunter, M.D., stated that an advisory letter would be appropriate in this case because the mammography report was most likely accurately read and the report does alert the physician of the area of concern and the six month delay would not have made a difference with the outcome. Dr. Hunter stated that there might have been some lack of follow up by the referring physician in a timely fashion. Dr. Hunter stated that the technical violation would be for failure to recommend cone views and an ultrasound in a timely fashion.

FORMAL INTERVIEWS (Continued) - HAROLD N. WALGREN, M.D.

MOTION: Tim B. Hunter, M.D., moved issue an advisory letter for failing to alert the referring physician to the seriousness of the patient's problem and for failing to follow up with the patient. A.R.S. § 32-1401(3) - "Advisory Letter" means a non-disciplinary letter to notify a licensee that: (d) The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE was taken and the following members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin III, M.D., Dona Pardo, Ph.D., R.N., and Edward J. Schwager, M.D. The following Board member was absent from this matter: Sharon B. Megdal, Ph.D. The following Board member was absent from the meeting: Ronnie R. Cox, Ph.D.
VOTE: 10-yay, 0-yay, 0-abstain/recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
2.	MD-02-0472A	AMB	MITZI J. BARMATZ, M.D.	24224	Dismissed; refer this case to the matter to the Nursing Board to review the nursing care.

Mitzi J. Barmatz, M.D., appeared before the Board with her attorney Tom Slutes. Tim B. Hunter, M.D., and Robert P. Goldfarb, M.D., recused themselves from this case. Sharon B. Megdal, Ph.D., arrived to the meeting at 9:00 a.m.

Robert Barricks, M.D., Board Medical Consultant reviewed this case with the Board. The case involves a settlement reached in a malpractice claim against Dr. Barmatz alleging that she erroneously ligated the patient's suprarenal aorta while performing a left radical nephrectomy to address a suspected left renal mass.

Patrick N. Connell, M.D., presenting Board member, began the questioning of Dr. Barmatz. Dr. Connell acknowledged that the patient had anatomical challenges. Dr. Barmatz stated that she has been participated with surgeries that involved two separate procedures at one time. Dr. Barmatz also stated that in this particular case, the gynecologist completed the first part of the surgery, which was the hysterectomy, then she completed her procedure, which was a left radical nephrectomy and this left her with no choice, but to perform the procedure through a midline infraumbilical incision. Dr. Barmatz stated that she does not know how a single silk ligature was placed encircling the entire aorta vessel.

The Board members questioned Dr. Barmatz. Dr. Barmatz stated that upon the assessment of the patient in the recovery room, she then checks with the family. Dr. Barmatz stated that during the night, after the surgery, she spoke with the resident on call who informed her that the patient had produced 500 cubic centimeter's (CC) of urine, but in fact the patient had not produced urine, but blood loss, and no one had recognized it at the hospital that night. Dr. Barmatz stated that now when she asks for an update on a patient from the nurses, she asks for specific vitals or specific questions.

Dr. Barmatz made a statement to the Board and stated that there were terrible complications and if there was any way that someone would have noticed there was no urine output, this situation could have been handled more expeditiously. Dr. Barmatz stated that she will live with that for the rest of her live, but she has learned from this experience.

Dr. Connell stated that there a tragic outcome and there was a horrendous error, but this physician was boxed in by several circumstances as the approach was unfamiliar to the physician along with some system problems that no one recognized that there was no urine output for twenty four hours. Dr. Connell stated that this physician is very well trained and careful and given the anatomical challenges, dictated by the approach and the failure of the team, he could not recommend discipline, therefore he recommended that this case be dismissed. Ram R. Krishna, M.D., noted the fact that she called that evening and questioned the staff regarding the patient. Dr. Krishna also stated that Dr. Barmatz was not informed that there was no urine output. Dr. Lee stated that he supports dismissal, as there were at least three people in there that did not recognize that there was not urine output. Dona Pardo, Ph.D., R.N., stated that the Nursing Board should look into the nursing staff regarding why the lack urine output was not caught and stated that the ball was dropped in that area. Dr. Krishna stated that the nurse did inform the resident on call and they did a fluid challenge, therefore he is having a problem referring the nurse to the Nursing Board. Dr. Pardo stated that the nurse should have notified the resident on call earlier, along with concern with the scanty notes and the accuracy of the nurse's assessment.

FORMAL INTERVIEWS (Continued) - MITZI J. BARMATZ, M.D.

MOTION: Ram R. Krishna, M.D., moved to dismiss this case; refer the matter to the Nursing Board to review the nursing care.

SECONDED: Becky Jordan

The following Board members voted in favor of the motion: Patrick N. Connell, M.D., Ingrid E. Haas, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N., and Edward J. Schwager, M.D. The following Board member voted against the motion: William R. Martin III, M.D. The following Board members were recused from the motion: Robert P. Goldfarb, M.D. and Tim B. Hunter, M.D. The following Board member was absent from the meeting: Ronnie R. Cox, Ph.D.

VOTE: 8-yay, 1-nay, 2-abstain/recuse, 1-absent

MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
3.	MD-03-0293A	AMB	DANIEL GENE NEHLS, M.D.	17213	Advisory Letter for operating at the wrong surgical level. The violation is a technical violation that is not of sufficient merit to warrant disciplinary action.

Daniel Gene. Nehls, M.D., appeared before the Board with his attorney Terry Woods.

Philip Scheerer, M.D., Board Medical Consultant reviewed this case with the Board. The allegation in this case is that Dr. Nehls improperly performed an anterior cervical fusion at the wrong level.

Dr. Nehls made a statement to the Board and stated that the surgery was performed on the wrong level and he accepts full responsibility for this. Dr. Nehls stated that in 20 years, he has never operated at the wrong level. Dr. Nehls stated that the nurse put the x-rays up for the surgery and they were identified by the last name, which happened to be the same last name of the next patient.

Robert P. Goldfarb, M.D., presenting Board member, began questioning Dr. Nehls. When Dr. Nehls was in the operating room, he put a spinal needle into the disk space, and then took an x-ray to compare the x-rays prior to proceeding. The Board confirmed that it was not his routine to put up his own x-rays, but use the registered nurse to do this step. Dr. Nehls stated that the needle was removed and that he coagulated around that area. Dr. Nehls also stated that he was amazed that he operated on the wrong level after finding out after the surgery. The Board members questioned how Dr. Nehls confirmed that the graft has not migrated after surgery. Dr. Nehls informed the Board that the grafts he uses are machine grafts, and then uses a plate to secure on each side. Dr. Nehls stated that he has never experienced complications with machine grafts and plates.

The Board members questioned Dr. Nehls. Dr. Nehls informed the Board that the x-ray film that was taken of the patient after the spinal needle was set in place was an adequate film. Dr. Nehls stated that he patient seemed to improve due to a placebo effect of the surgery.

Terry Woods made a statement to the Board on behalf of Dr. Nehls. Mr. Woods informed the Board that the Washington State Medical Quality Assurance Commission dismissed this case. Mr. Woods stated that there was an expert opinion that Dr. Nehls was not at fault and that a letter of reprimand would not be appropriate, as this is not an offense that requires discipline.

Robert P. Goldfarb, M.D., stated that this is not easy because when one is performing cervical surgery there are many pitfalls, as Dr. Nehls mentioned in his testimony very well. Dr. Goldfarb stated that there are many traps that good physicians can fall into, however it is incumbent upon the surgeon to document the level that they are working at. Dr. Goldfarb stated that this falls below the standard of care under A.R.S. § 32-1401(26) - "Unprofessional conduct" includes the following, whether occurring in this state or elsewhere: (q) Any conduct or practice that is or might be harmful or dangerous to the health of the patient or public. Dr. Goldfarb stated that the Washington State Medical Quality Assurance Commission concluded that action was not warranted. Dr. Goldfarb also stated that the Medical Consultant, who reviewed this case, set the standard very high in regards to when the post operative x-ray should be taken, and stated that we cannot hold Dr. Nehls to that standard. Dr. Goldfarb recommended that the Board issue Dr. Nehls an advisory letter for a technical violation as this does not rise to the level of discipline. Dr. Schwager stated that Dr. Nehls has changed his procedures since this case and there is lack of evidence to support disciplinary action. Tim B. Hunter, M.D., stated that another state Board reviewed this case and dismissed its investigation. Dr. Hunter also stated that the physician is very competent. Dr. Goldfarb stated that there is a distinction operating on the wrong limb or side, but that would not be in the same category as this.

FORMAL INTERVIEWS (Continued) - DANIEL GENE NEHLS, M.D.

MOTION: Robert P. Goldfarb, M.D., moved to issue an advisory letter for operating at the wrong surgical level. A.R.S. § 32-1401(3) - "Advisory Letter" means a non-disciplinary letter to notify a licensee that: (d) The violation is a technical violation that is not of sufficient merit to warrant disciplinary action.
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE was taken and the following members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N., and Edward J. Schwager, M.D. The following Board member was absent from the meeting: Ronnie R. Cox, Ph.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
4.	MD-02-0663A	E.W.	MALCOLM G. WILKINSON, M.D.	21001	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for repeatedly failing to cooperate with Board staff in the process of investigating this complaint.

Malcolm G. Wilkinson, M.D. appeared before the Board without legal counsel. Douglas D. Lee, M.D. stated that he knows Dr. Wilkinson, but this will not affect his ability to adjudicate this case.

Roderic Huber, M.D., Board Medical Consultant reviewed this case with the Board. The allegation in this case is that Dr. Wilkinson failed to timely provide results of a gastrointestinal (GI) endoscopy to the patient or his primary care referring physician; failed to provide any recommendation for further testing and/or treatments of the patient's ulcers; failed to timely provide information to Board staff, and failed to appear for, or reschedule, his subpoenaed Investigational Interview.

Dr. Wilkinson made a statement to the Board and stated that he does not deny the allegations. Dr. Wilkinson stated that there was a delay in relaying information to the patient's family and his responses to the Board were lacking, but there seemed to be some confusion.

William R. Martin III, M.D., presenting Board member, began the questioning of Dr. Wilkinson. Dr. Wilkinson stated that he was overworked and took time off to regroup. Dr. Wilkinson also stated that procedures have been implemented in his office to prevent any lack of patient communication, as there were phone calls from the patient that were left unanswered. Dr. Wilkinson stated that phone messages are now forwarded to him directly and are answered within one to two days. Dr. Wilkinson stated that he did not respond to the Board's inquiries because of another case at the same time, but has no explanation as to why he did not return the Board's phone calls. Dr. Wilkinson stated that he was previously given a letter of reprimand that was published and led to many adverse effects on his practice, so he was angry at the Board and intentionally became unresponsive to them. Dr. Wilkinson stated that he does understand the Arizona statutes regarding not being responsive to the Board's inquiries.

Carlyle Fleming, Quality of Care Division Chief, stated that the notice letters were mailed to Dr. Wilkinson within approximately a month of each other regarding two separate cases.

William R. Martin III, M.D., stated that the initial item for which the physician was noticed would most likely not rise to the level of discipline, however this physician's unresponsiveness to the Board was intentional and is a serious matter that cannot be ignored. Dr. Martin also stated that the first allegation has been sustained by the physician's testimony; allegation number two he agreed with; and allegation number three is substantiated and recommended for a finding of unprofessional conduct in violation of A.R.S. § 32-1401(26) - "Unprofessional conduct" includes the following, whether occurring in this state or elsewhere: (r) Violating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under the provisions of this chapter and (dd) Failing to furnish information in a timely manner to the board or the board's investigators or representatives if legally requested by the Board. Dr. Hunter stated that it was very unkindly to be unresponsive to the Board, but appreciates the physician's honesty for admitting to the fact that he was mad at the Board, however, not picking up the phone and responding to Board Orders is unprofessional conduct.

MOTION: William R. Martin III, M.D., moved for a finding of unprofessional conduct in violation of A.R.S. § 32-1401(26) - "Unprofessional conduct" includes the following, whether occurring in this state or elsewhere: (r) Violating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under the provisions of this chapter, and (dd) Failing to furnish information in a timely manner to the board or the board's investigators or representatives if legally requested by the Board.
SECONDED: Tim B. Hunter, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

FORMAL INTERVIEWS (Continued) - MALCOLM G. WILKINSON, M.D.

Dr. Martin stated that the mitigating factors involved in this case is the physician's displeasure with the Board and he understands how one can become angry with the Board and the other factor involved is the physician mentioned a burden of being busy and would recommend a letter of reprimand.

MOTION: William R. Martin III, M.D., moved for Board staff to draft findings of fact, conclusions of law and order for a letter of reprimand for repeatedly failing to cooperate with Board staff in the process of investigating this complaint.
SECONDED: Tim B. Hunter, M.D.
ROLL CALL VOTE was taken and the following members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N., and Edward J. Schwager, M.D. The following Board member was absent from the meeting: Ronnie R. Cox, Ph.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
5.	MD-03-0018B	AMB	MALCOLM G. WILKINSON, M.D.	21001	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to identify and protect a single ureter during a surgical procedure and for repeated failure to respond to the Board during the investigation.

Malcolm G. Wilkinson, M.D., appeared before the Board without legal representation. Douglas D. Lee, M.D. stated that he knows Dr. Wilkinson, but this will not affect his ability to adjudicate this case.

Roderick Huber, M.D., Board Medical Consultant reviewed this case with the Board. The allegation in this case is that Dr. Wilkinson negligently performed a colonoscopy with biopsy and, in the course of resecting a portion of the colon, damaged and/or transected the ureter; and failed to respond to written and verbal requests to provide information to the Board.

Dr. Wilkinson made a statement before the Board and stated that this particular day a urologist was not available. Dr. Wilkinson stated that after surgery the patient did have a small amount of urine output that dropped off and he thought the appropriate studies were done. Dr. Wilkinson also stated that when it came time to decide to do dialysis, the patient decided to forgo any treatment. Dr. Wilkinson stated that this case was peer reviewed by the hospital, where it was agreed that more protective measures should have taken place to protect the ureter.

Ingrid E. Haas, M.D., presenting Board member began the questioning of Dr. Wilkinson. Dr. Wilkinson stated that he checks the ureter to ensure it would not be in the path of the instruments that were being used. Dr. Wilkinson stated that he would not normally use dyes to check a ureter after surgery if he feels confident that the ureter has been preserved. Dr. Wilkinson stated that there were recordings of urine output as part of the nurse's documentation, but this output dropped off within about twenty-four hours. Dr. Wilkinson stated that he did proceed with an ultrasound or computed tomography scan (CT) by the next day to evaluate the lack of urine output. Dr. Wilkinson stated that there were signs that this was acute renal failure. Dr. Wilkinson stated that the delay was due to the radiologist's decision, as the problem was discussed between three physicians. Dr. Wilkinson stated that he does not know of the reason, but stated that it was not a good decision. Dr. Wilkinson stated that if they were not able to relieve the obstruction then the patient would need to be explored.

Dr. Wilkinson stated he has nothing to add to the facts of the case. Dr. Wilkinson stated that this was a difficult situation due to the patient not being agreeable to pre-exploration, but the physicians did take the time to do the procedure with care. Dr. Wilkinson also stated that looking back, this most likely would have been avoided if steps were taken to protect and ensure the ureter was intact during surgery.

Carlyle Fleming, Quality of Care Division Chief, stated again the physician failed to respond to the Board's investigation.

Dr. Haas stated that with allegation number one, the physician stated that he would normally put a stent in, but did not in this case and the colon can easily be injured and an interoperative dye study would have been appropriate. Dr. Haas stated as far as allegation number two, there is a failure to respond to the Board. Dr. Haas recommended for a finding of unprofessional conduct in violation of A.R.S. § 32-1401(26) - "Unprofessional conduct" includes the following, whether occurring in this state or elsewhere: (ll) Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient. Dr. Haas stated that the standard of care was to protect the single remaining ureter in a patient who had previously undergone a nephrectomy and the standard was deviated by not using the stent, which resulted in the loss of a kidney and the ultimate demise of the patient. Dr. Haas also recommended a violation of A.R.S. § 32-1401(26) - "Unprofessional conduct" includes the following, whether occurring in this state or elsewhere: (dd) Failing to furnish information in a timely manner to the board or the board's investigators or representatives if legally requested by the Board.

FORMAL INTERVIEWS (Continued) - MALCOLM G. WILKINSON, M.D.

MOTION: Ingrid E. Haas, M.D., moved for a finding of unprofessional conduct in violation of A.R.S. § 32-1401(26) - "Unprofessional conduct" includes the following, whether occurring in this state or elsewhere: (ll) Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient and (dd) Failing to furnish information in a timely manner to the board or the board's investigators or representatives if legally requested by the Board.
SECONDED: William R. Martin III, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

Ingrid E. Haas, M.D., stated this case is challenging and due to the track record of disciplinary action and numerous failures to respond to the Board and the Staff Investigational Review Committee (SIRC) recommendation for a decree of censure, because of the numerous violations. William R. Martin III, M.D., stated he supports the motion for a decree of censure and would have considered a letter of reprimand, but this rises to the level of discipline after looking at the evidence of this case. Edward J. Schwager, M.D., stated that he is supportive of the disciplinary action, but not totally in support of a decree of censure. Dr. Schwager stated that on a procedural basis, would we have been better off combining the allegations in one case and then dealing with the quality of care issues and so on this basis he has concerns raising this to a decree of censure, although, there is enough information and evidence here to support a decree of censure. Dr. Martin stated that Dr. Schwager's comments are appropriate. Dr. Goldfarb stated that it is unfortunate that both of these cases came to the Board on the same day and at the same time. Dr. Goldfarb would support a letter of reprimand rather than a decree of censure. Sharon B. Megdal, Ph.D., recommended that the motion be amended to a letter of reprimand. Dr. Hass and Dr. Hunter agreed with the amendment

MOTION: Ingrid E. Haas, M.D., moved for Board staff to draft findings of fact, conclusions of law and order for a letter of reprimand for repeated failure to comply with Board investigative staff and for failure to identify and protect a single ureter during a surgical procedure.
SECONDED: William R. Martin III, M.D.
ROLL CALL VOTE was taken and the following members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N., and Edward J. Schwager, M.D. The following Board member was absent from the meeting: Ronnie R. Cox, Ph.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
6.	MD-03-0447A MD-02-0599A MD-03-0330A	AMB	GERALD J. TAITAGUE, M.D.	26182	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand with a 24 month Probation including recommendations from Betty Ford Clinic; 20 hours of continuing medical education (CME) in prescribing controlled substances, to be completed in one year, in addition to the CME required for licensure renewal; 12 months psychotherapist, approved by Board staff, to assist with recommendations from Betty Ford Staff, progress monitored with quarterly reports to Board; 12 months of random urine tests; charts re-reviewed this case with the Board. In one year's time to determine progress in his approach to dealing with controlled substances. The physician may not request termination of the Probation.

Gerald J. Taitague, M.D., appeared before the Board with his attorney John Black. William R. Martin III, M.D., recused himself from this case. Douglas D. Lee, M.D., was not present when this matter was discussed.

Beatriz Garcia Stamps, M.D., M.B.A., Medical Director reviewed the cases with the Board. MD-03-0447A - The allegation in this case is that Dr. Taitague, GP/PD, wrote a prescription for Tylenol with Codeine, a controlled medication, to a fictitious patient in order to obtain and use the medication for himself. MD-02-0599A – The allegation in these case is that Dr. Taitague failed to disclose on his application for staff medical privileges at Winslow Memorial Hospital August 2, 2002 that his medical privileges were revoked at Weed Army Community Hospital (WACH) on August 23, 2001. MD-03-0330A – The primary allegation in this case is that Dr. Taitague prescribed large amounts of controlled medications to 9 patients. The secondary allegation is that Dr. Taitague inappropriately self-prescribed Stadol, a Schedule IV pain medication.

Gerald J. Taitague, M.D., made a statement before the Board and stated that he admits to all of the allegations and takes responsibility for all of them.

Patrick N. Connell, M.D., presenting Board member began questioning Dr. Taitague. Dr. Taitague stated that he was prescribing pain medication, but was uncertain about what was appropriate or inappropriate and followed the prescription guidelines to care for the patient. Dr. Connell stated that during the investigational interview, the Board's guidelines regarding prescribing were pointed out to Dr. Taitague. Dr. Taitague agreed, but stated that this was after this particular incident occurred. Dr. Taitague

FORMAL INTERVIEWS (Continued) - GERALD J. TAITAGUE, M.D.
stated that he does understand the boundary issues and when he writes prescriptions and a patient goes from one physician to another, he is not informed of it unless the pharmacy notifies him. Dr. Taitague stated that his prescribing to the patients was excessive and inappropriate.

The Board members questioned Dr. Taitague. The Board members stated there are issues of prescribing and asked Dr. Taitague if he has considered taking courses for prescribing. Dr. Taitague informed the Board that he has considered this. Dr. Taitague currently takes a complete history of patient and refers the patient to a pain specialist to evaluate what treatments would be appropriate and necessary.

Mr. Black made a statement to the Board on behalf of Dr. Taitague and asked the Board to allow Dr. Taitague to practice medicine. Mr. Black stated that there has never been an instance regarding abuse of any kind and Dr. Taitague is ready and willing to do whatever the Board imposes on him to keep practicing.

Dr. Connell stated that by his own admission that he has violated the medical practice act specifically in A.R.S. § 32-1401(26) "Unprofessional conduct" includes the following, whether occurring in this state or elsewhere: (g) – Using controlled substances except if prescribed by another physician for use during a prescribed course of treatment. A.R.S. § 32-1401(26)(t) – Knowingly making any false or fraudulent statement, written or oral, in connection with the practice of medicine or if applying for privileges or renewing an application for privileges at a health care institution. A.R.S. § 32-1401(26)(p) – Sanctions imposed by an agency of the federal government, including restricting, suspending, limiting or removing a person from the practice of medicine or restricting that person's ability to obtain financial remuneration. And A.R.S. § 32-1401(26)(q) - Any conduct or practice that is or might be harmful or dangerous to the health of a patient or the public. Dr. Connell stated this would bee for all three case numbers MD-03-0447A, MD-02-0599A, and MD-03-0330A.

MOTION: Patrick N. Connell, M.D., moved for a finding of unprofessional conduct in violation of A.R.S. § 32-1401(26) "Unprofessional conduct" includes the following, whether occurring in this state or elsewhere: (g) – Using controlled substances except if prescribed by another physician for use during a prescribed course of treatment. A.R.S. § 32-1401(26)(t) – Knowingly making any false or fraudulent statement, written or oral, in connection with the practice of medicine or if applying for privileges or renewing an application for privileges at a health care institution. A.R.S. § 32-1401(26)(p) – Sanctions imposed by an agency of the federal government, including restricting, suspending, limiting or removing a person from the practice of medicine or restricting that person's ability to obtain financial remuneration. And A.R.S. § 32-1401(26)(q) - Any conduct or practice that is or might be harmful or dangerous to the health of a patient or the public.
SECONDED: Ram R. Krishna, M.D.
VOTE: 9-yay, 0-nay, 1-abstain/recuse, 2-absent
MOTION PASSED.

Patrick N. Connell, M.D., stated these are very serious matters and Dr. Taitague recognizes this. The Staff Investigational Review Committee recommended a decree of censure with a five-year probation, but Dr. Taitague has admitted remorse and a willingness to move forward with self-improvement and this speaks in mitigation. Dr. Connell recommended that Board Staff draft findings of fact, conclusions of law and order for a letter of reprimand with a five year probation to include the recommendations from Betty Ford Clinic; 20 hours of continuing medical education (CME) in prescribing controlled substances approved by Board staff, to be completed in one year, in addition to the CME required for licensure renewal; 12 months psychotherapist, approved by Board staff, to assist with recommendations from Betty Ford Staff, progress monitored with quarterly reports to Board; 12 months of random urine tests; charts re-reviewed this case with the Board in one year's time to determine progress in his approach to dealing with controlled substances. The physician may not request termination of the Probation. Sharon B. Megdal, Ph.D., commented that a two-year probation would seem more appropriate. Dr. Connell amended his motion to include 24 months of probation in lieu of five years. Dr. Pardo stated that Dr. Taitague has done some CME in the areas recommended. Dr. Connell stated that he did intend to include the CME as recommended.

FORMAL INTERVIEWS (Continued) - GERALD J. TAITAGUE, M.D.

MOTION: Patrick N. Connell, M.D., moved for Board staff to Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand with a 24 month Probation including recommendations from Betty Ford Clinic; 20 hours of continuing medical education (CME) in prescribing controlled substances, to be completed in one year, in addition to the CME required for licensure renewal; 12 months psychotherapist, approved by Board staff, to assist with recommendations from Betty Ford Staff, progress monitored with quarterly reports to Board; 12 months of random urine tests; charts re-reviewed this case with the Board. In one year's time to determine progress in his approach to dealing with controlled substances. The physician may not request termination of the Probation.
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE was taken and the following members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N., and Edward J. Schwager, M.D. The following Board member was recused from this matter: William R. Martin III, M.D. The following Board member was absent when this case was discussed: Douglas D. Lee, M.D. The following Board member was absent from the meeting: Ronnie R. Cox, Ph.D.
VOTE: 9-yay, 0-nay, 1-abstain/recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
7.	MD-96-0746	AMB	GUSTAVE MATSON, M.D.	15992	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for violating a Board Order.

Gustave Matson, M.D., appeared before the Board with his attorney Terry Woods.

Philip Scheerer, M.D., Board Medical Consultant reviewed this case with the Board. Dr. Scheerer stated that Dr. Matson violated the Board Order by attending to a female patient without a chaperone in violation A.R.S. § 32-1401(26)(r) – Violating a formal order, probation, consent agreement, or stipulation issued or entered into by the board or its executive director under the provisions of this chapter.

Gustave Matson, M.D., made a statement before the Board. Dr. Matson stated that he has always been in compliance with the Board Order. Dr. Matson stated that the nurses are most helpful and willing to be a chaperone for him to comply with his Board Order, but at this particular time, a nurse was not available to him at the hospital, which left him with the decision to see a patient with a post-operative wound without a chaperone, or not tend to the patient.

Sharon B. Megdal, Ph.D., presenting Board member, began questioning Dr. Matson. Dr. Matson stated that he was aware that the hospital could report to the Board. Dr. Matson stated this happened due to the fact that the nursing staff was short and had an increase the patient care. Dr. Matson stated his previous legal counsel advised him that, although he knew it was difficult to comply with the Board Order in the hospital setting, he should not try to modify his Board Order. Sharon B. Megdal, Ph.D., noted for the record that this formal interview was noticed as a compliance issue. Mr. Woods stated that Dr. Matson is not practicing obstetrics because of a previous Board Order and that he is planning on keeping an active license, but because of this matter, he would not be able to take call at night.

The Board members questioned Dr. Matson. The board members inquired if there was any other infraction during this time that made the hospital report this to the Board. Dr. Matson also stated that due to the hours he works it would be prohibitive to him to hire a registered nurse or physician assistant approved by the hospital.

Dr. Megdal stated that this is a straightforward case being that the physician admitted the violation of the Board Order. Dr. Megdal stated that the original Order was entered as a result of the case to a stipulation and then a corrective order. Dr. Megdal also stated that the required chaperoning is taken quite seriously. Dr. Megdal recommended that this physician has violated the terms of the Board Order.

MOTION: Sharon B. Megdal, Ph.D., moved for a finding that Dr. Matson violated the terms of the Board Order.
SECONDED: Ram R. Krishna, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

The Board members clarified with Mike Zakrzewski, Senior Compliance Officer, that the records reviewed were randomly chosen by the hospital.

FORMAL INTERVIEWS (Continued) - GUSTAVE MATSON, M.D.

MOTION: Sharon B. Megdal, Ph.D., moved for Board staff to draft findings of fact, conclusions of law and order for a letter of reprimand for violating a Board Order.
SECONDED: Douglas D. Lee, M.D.
ROLL CALL VOTE was taken and the following members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N., and Edward J. Schwager, M.D. The following Board member was absent from the meeting: Ronnie R. Cox, Ph.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
8.	MD-03-0443A	AMB	CAYETANO S. MUNOZ, M.D.	9506	Interim Order for Physician Assessment and Clinical Education program (PACE) course in anesthesia or other anesthesia course approved by Board staff and obtain a neurological examination; the case is continued until anesthesia course and a neurological evaluation are completed and the results are presented to the Board. They physician remains under the current Order.

Cayetano S. Munoz, M.D., appeared before the Board. Dr. Munoz informed the Board that his counsel would be late and requested that the proceedings be delayed until his attorney arrived. Edward J. Schwager, M.D., granted the delay. The formal interview resumed after the arrival of Dr. Munoz's attorney Dan Ballecer.

Beatriz Garcia Stamps, M.D., M.B.A., Medical Director reviewed this case with the Board.

Cayetano S. Munoz, M.D., made a statement to the Board and stated that he would gladly oblige with anything the Board imposes in order to keep practicing.

Robert P. Goldfarb, M.D., presenting Board member began questioning Dr. Munoz. Dr. Munoz stated that the Mayo Clinic did a complete examination and also stated that he is monitoring his own blood pressure.

The Board members questioned Dr. Munoz. Dr. Hunter informed the Board his concern is that if Dr. Munoz were to work long hours, his health would be affected and this could cause harm to the public. Dr. Hunter asked Dr. Munoz if he would be willing work limited hours. Dr. Munoz stated that he checks the ears, nose and throat and general appearance, weight, difficulty breathing, thyroid, heart, lungs, aorta, kidneys, abdominal, and extremities of the patients. Dr. Lee stated his desire for Dr. Munoz to continue to work, but yet keep the public safe. Robert P. Goldfarb, M.D., recommended that Dr. Munoz's practice be restricted and not practice anesthesia. Edward J. Schwager, M.D., stated that anesthesia is where he serves best. Dr. Goldfarb stated that one cannot always control one's practice and at this point the Board does not have enough information to prohibit this physician from practicing at all. Dr. Lee stated that if a third party source, after a two-week course, reports Dr. Munoz as competent, the Board would be able to then allow him to practice. Dr. Lee stated that the question is if Dr. Munoz is ready to return to anesthesia without restricting his practice to specific types of anesthesia. Ram R. Krishna, M.D., stated that a better solution might be to have supervision. Dr. Lee recommended a two-week physician assessment and clinical education program (PACE) anesthesia course, with a report after completion that Dr. Munoz would be safe to practice anesthesiology. Dr. Goldfarb recommended that Dr. Munoz also undergo a neurological examination and that the Board continue this matter until after that evaluation is returned to the Board. Dr. Lee commented that it was very commendable that Dr. Munoz has complied with every single order of the Board and that his past, with no problems, speaks of his ability to perform anesthesia.

MOTION: Robert P. Goldfarb, M.D., moved for and Interim Order for Physician Assessment and Clinical Education program (PACE) course in anesthesia or other anesthesia course approved by Board staff and obtain a neurological examination; the case is continued until anesthesia course and a neurological evaluation are completed and the results are presented to the Board. They physician remains under the current Order.
SECONDED: Patrick N. Connell, M.D.
ROLL CALL VOTE was taken and the following members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N., and Edward J. Schwager, M.D. The following Board member was absent from the meeting: Ronnie R. Cox, Ph.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

CONSIDERATION OF SUMMARY ACTION

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
1.	MD-03-0248A	AMB	WILLIAM NEAL CHLOUPEK, M.D.	4553	Summary Restriction of Dr. Chloupek's license. He shall not practice clinical medicine until successful completion of an in-patient treatment program approved by Board staff and enters into a monitoring program. He can then reapply to the Board to return to the practice of clinical medicine.

William Neal Chloupek, M.D. appeared before the Board with his attorney Lisa Davis. E.K. made a statement to the Board at the call to the public. J.C. made a statement to the Board at the call to the public. D.M. made a statement to the Board at the call to the public.

Chris Bingham, Division Chief, reviewed this case with the Board and referred the Board to the materials previously provided to them. Dr. Greenburg informed the Board of his concern regarding a possible relapse of this physician. Dr. Greenburg stated that Dr. Chloupek had relapsed due to his use of alcohol. A third evaluation was performed by the Betty Ford Center at the request of the Board and during that evaluation Dr. Chloupek admitted that his use of alcohol and use of Ritalin and Ambien was inappropriate.

Ms. Davis made a statement to the Board on behalf of Dr. Chloupek. Ms. Davis shared a letter with the Board from Dr. Chloupek's treating psychiatrist.

Steve Wolf, Assistant Attorney General, made a statement to the Board. Mr. Wolf informed the Board that Dr. Chloupek's recovery has not been monitored, and the last time he had a problem, it required 9 months of treatment. Mr. Wolf stated that Dr. Chloupek had not been clinically diagnosed as having Attention Deficit Disorder, but that Dr. Chloupek had been depressed and that Ritalin is not a treating drug for depression. Mr. Wolfe stated that Ritalin has been Dr. Chloupek's drug of choice. Mr. Wolf stated that the Board has been asked to consider a summary action because of Dr. Chloupek's refusal to admit his relapse. Mr. Wolf noted that this is a physician who is certified in addiction medicine, yet shows no insight into his own relapse.

Dr. Greenburg made a statement to the Board. Dr. Greenburg stated that Dr. Chloupek failed to understand that prescribing any amount of narcotics is detrimental to a recovering addict. Dr. Greenburg stated that Dr. Chloupek had claimed he was taking Ritalin for depression, but his treating physician contradicted this and noted that the Ritalin was for fatigue. Dr. Greenburg stated that there are concerns of Dr. Chloupek's competency and there has been no proof that abstinence has been maintained. Dr. Greenburg stated that in response to a specific inquiry from an evaluating facility as to what would happen if Dr. Chloupek did not admit his relapse and voluntarily remove himself from practice, he stated that the refusal would result in the Board considering an emergency suspension hearing. Dr. Greenburg informed the Board that he had no contact with Betty Ford before or during Dr. Chloupek's evaluation, but after the evaluation was complete, the Betty Ford Center warned him that the previous evaluations would be inaccurate because Dr. Chloupek had withheld the truth from those evaluators. Ms. Davis stated that Dr. Chloupek has taken urine tests that she can provide to the Board at a later date.

Edward J. Schwager, M.D., moved to go into executive session at 5:30 p.m.
SECONDED: Ram R. Krishna, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

The Board returned to open session at 5:43 p.m.

Patrick N. Connell, M.D., stated that the physician has a problem acknowledging his addiction problem and recommended a summary restriction from clinical practice until successful treatment has been completed.

MOTION: Patrick N. Connell, M.D., moved for a summary restriction of Dr. Chloupek's license. He shall not practice clinical medicine until successful completion of an in-patient treatment program approved by Board staff and enters into a monitoring program. He can then reapply to the Board to return to practice of clinical medicine.
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE was taken and the following members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N., and Edward J. Schwager, M.D. The following Board member was absent from the meeting: Ronnie R. Cox, Ph.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

Meeting adjourned at 5:48 p.m.

[Seal]

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Barry A. Cassidy, Ph.D., P.A.-C, Executive Director